ASSESSMENT OF FACTORS AFFECTING IMPLEMENTATION OF COMMUNITY HEALTH STRATEGY IN MOGOTIO SUB COUNTY, BARINGO, KENYA

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DECLARATION AND APPROVAL

DECLARATION

This thesis is my original work and has not been presented for degree in any other university or for any other award.

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We confirm that the work reported in this thesis was carried out by the candidate under our supervision

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DEDICATION

I would like to dedicate this work to all community health providers for their commitment to serve communities . May God bless you.

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ABSTRACT

The community health strategy (CHS) approach is one of the Kenya's flagships of vision 2030, intending to improve well being care services of rural communities. This study therefore assessed factors influencing the enactment of CHS in Mogotio Sub County, Baringo County, Kenya. The study applied cross-sectional study design in collecting primary data. The study was conducted in three locations of Mogotio sub-county namely Koitebes, Ngubereti and Sirwa location. Study design was cross-sectional based with a target population of 12406 and studied population (household heads) of 2410. Simple random sampling was used to select household head respondents and purposive sampling to select key informants and the piloting study was undertaken in Emining location, Emining ward. The study involved 320 respondents and the target groups were Community health volunteers (CHVs) Community health extension workers (CHEWs), household head (HHH) and county health management team (CHMT). Data was analyzed quantitatively (mean and percentages) and inferentially. For inferential statistics, Spearman's correlation analysis was used to determine the influence of participation by the county administration as well as the challenges faced by County Administration and the community well-being volunteers on the enactment of the community well-being approach using the 21st version of Statistical Package for the Social Sciences (SPSS) with 0.05 level of significance. Data was presented in tables, pie charts and bar graphs. Dissemination of information on CHS to the members of households was low or non-existent,probably because the training and facilitation offered to CHVs was poor and inadequate creation of awareness to the local community in the enactment of the program. The findings indicated that majority (51%) of the household head respondents were male and 49% female. Through Spearman's correlation test, all the contributions and challenges by both the community well-being volunteers and the county administration had a significant influence on the enactment of the community well-being approach ($P<0.05$). The study also revealed that the CHVs were not adequately trained on both the basic and technical modules. Based on the study findings, it is recommended that the county administration need to ensure that CHVs are well trained on both the basic and technical modules and also provide all the required resources for proper enactment of the CHS program.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACSM-Advocacy Communication Social Mobilization

ANC-Ante-Natal Clinic

BFCI-Baby friendly community initiative

BCC- Behavior change communication

ESAR-East and Southern African Region

CBP- Community Based Provisions

CEC-County Executive Committee

CHP-Community well-being Promoters

CCSFP-County Community Approach Focal Person

CHC –Community well-being Committee

CHS- Community well-being Approach

CHU- Community well-being Unit

CHEWs-Community well-being Extension Employees

CHVs – Community well-being Volunteers

CHW – Community well-being Worker

COH- Chief Officer of Wellbeing

CPHO-County public wellbeing officer

CU – Community Unit

FHF- Fred hollows foundation

FP- Family planning

HH- Household

HHH- Household Head

HRH- Human Resources for Wellbeing

ICCM-Integrated Community Case Management

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IEC – Information Education Communication

IGA-Income Generating Activity

KEMSA-Kenya medical supplies agency

KEPH-Kenya Essential Package for Wellbeing

KHSSP-Kenya Wellbeing Sector Strategic Plan.

MNCH-Maternal neonatal child wellbeing

MDG –Millennium Development Goal

MOH-Ministry of Wellbeing

NGOs-Non-Administrational Organizations

NHSSP-National Wellbeing Sector Strategic Plan

PHC-Primary Wellbeing Care

OJT-On job training

RoK- Republic of Kenya

RoM- Republic of Malawi

RoU- Republic of Uganda

RoR –Republic of Rwanda

SCHSC-Sub County Wellbeing Service Coordinator

SDG-Sustainable Development Goals

WASH-Water sanitation and hygiene

WHO-World Wellbeing Organization

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CHAPTER ONE

1.0 INTRODUCTION

This chapter comprises the research background, statement of the problem, the purpose/general objective of the study, objectives, research questions, study justification, the study scope, study limitations, delimitations, assumptions of the study and definition of operational terms.

1.1 Study Background

Globally, the community well-being approach has been viewed as a projectile way in bringing improvement in wellbeing care service delivery and addressing the heavy burden of disease and also enhances the growth of wellbeing and socio-economic development(WHO, 2010). Many countries in the world tackle problems of inadequate wellbeing care providers by utilizing Community well-being Employees and also ensuring that the Community well-being Employees provide primary wellbeing care services to their fellow community members (RoK, 2017). A community approach is an approach to delivering Kenya's Essential Package for Wellbeing (KEPH) at level one (RoK, 2017). Community well-being services were established in Rwanda in the year 1995 to deal with two important challenges which were a lack of enough well-being care employees and inaccessibility to well-being care services. The estimation of life expectancy was found to be at 31 years and 2 months and the maternal death rate was at 1071 per 100,000 live births. Under the five-year mortality rate was at 196 per 1000 and infant death rate was projected to be at 107 per 1000 live births (World Bank, 2015).

The successful enactment of community well-being strategies in Africa are influenced by various factors (Schneider and Nxumalo, 2017). Adequate funding is necessary to ensure that community well-being programs have the necessary resources to function effectively. Insufficient funding can hinder the enactment of community well-being programs and limit their impact. Community well-being strategies require trained well-being care employees who can effectively deliver wellbeing services to communities. However, in many parts of Africa, trained well-being care employees are scarce, which can hinder the successful enactment of community well-being programs. Poor infrastructure and logistics can also affect the enactment of community well-being programs. In many parts of Africa, the

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insufficient presence of infrastructures, such as roads and transportation, which can make it difficult for well-being care employees to reach remote communities and deliver services. The involvement and ownership of the local community in the enactment of community well-being strategies is critical for their success. Without community involvement and ownership, programs may not be sustainable or effective in meeting the wellbeing needs of the community. Political will and leadership are critical for the successful enactment of community well-being programs. Administrations must prioritize community well-being programs and provide the necessary support and resources for their enactment. Cultural and social factors can also affect the enactment of community well-being programs. Cultural beliefs and does can influence the acceptability and effectiveness of wellbeing interventions, while social factors such as poverty and gender inequality can impact access to wellbeing services. Addressing these factors can help to improve the enactment of community well-being strategies in Africa and ensure that they are effective in improving the wellbeing and wellbeing of communities (Bakibinga et al., 2020; Adebisi et al., 2021).

The Community well-being Volunteers' activities were appropriately designed in the national CHV policy of 2015 which gives such an opportunity. Thus, the policy recognizes the need for Community well-being Volunteers and gives more suggestions on the need to ensure a more inclusive CHV program. The policy document recognizes need to have CHVs alongside Wellbeing Surveillance Assistance (HSAs), in the delivery of wellbeing services at the community (RoM, 2015). The community well-being approach aims at improving the community's knowledge and skills which will boost their routine wellbeing practices. CHS encourages communities to be responsive to attain the highest possible wellbeing status which is a vital community's social goal (WHO, 2013). The community well-being model is based on the wholesome primary wellbeing care concept which focuses on the ideals of collaboration, the contribution of the community and strengthening the community by giving adequate resources that will ensure affordable, equitable and accessible wellbeing care. The community well-being approach is identified as a way of delivering wellbeing for all in the community (RoK, 2016).

Mogotio Sub County is one of the six Sub Counties of Baringo County. It had thirty-two public wellbeing facilities and nine Community Units. The Sub County needs a total of

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twenty- two community well-being units to cover the whole of it, which translates to 40% community unit coverage(RoK, 2016). A resolution to implement community well-being activities needs bold policy decisions and guidelines from the administration and all the various departments in the wellbeing sector (WHO, 2015. The community well-being approach includes wellbeing services devolved to counties but the development of policy, standards and technical assistance to counties remain key functions of the National administration (RoK, 2017). Community well-being employees provide service at level one which is community and they should be linked to the wellbeing system in general if they are to be effective in their work. A lot of attention concerning Universal Wellbeing Coverage (UHC) has been focused on financial risk protection and loss more than focusing on coverage of effective well-being care services (World Bank, 2015). It is important to note that the first flagship project under well-being in vision 2030 was to revitalize the community well-being approach to promote protective well-being care and promote well-being individual lifestyles which implies that community well-being sits at the center of vision 2030's urgency areas (RoK, 2017).

Universal Wellbeing Coverage (UHC) is a significant unit of the Maintainable Development Goals (SDGs). The important aspect of the UHC is the kind of wellbeing services offered in the community. A country can achieve UHC in a step-by-step manner and over time provision of services can expand to form part of a continuous changing that ranges from preventive and curative services. (WHO,2014). The Community well-being Unit (CHU) is a structure of households organized in functional villages or sub-locations formally identified as the first tier in the Kenya Wellbeing System. Community well-being Volunteers provide wellbeing services that improve the community's wellbeing and wellbeing and to facilitate referrals of individuals to wellbeing facilities (RoK, 2012).

Community well-being Volunteers (CHVs) provided wellbeing services to the communities in Rwanda and hence provided part of the solutions Rwanda needed in improving the wellbeing status of community members. CHVs also provided wellbeing education to the communities so as to be responsive for their wellbeing. The CHV programs have contributed to Rwanda's impressive progress in the wellbeing sector (RoR, 2017). It is shown by evidence that the CHVs provide wellbeing services which have helped to address wellbeing

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problems especially in the rural communities. CHVs work has also helped in the decrease of children getting sick and dying, increase vaccination and uptake and promotion of breast feeding. Because of this success and the rampant shortage of wellbeing care employees, a good number of African and South East Asian countries are putting plans in place and are also implementing CHVs program (Greenspan et al., 2013).

1.2 Problem Statement

The ministry of Wellbeing launched the CHS in 2006 in all the provinces as part of the commitment Kenya had stated to ensure that all citizens get good wellbeing. CHS enactment at the community is done by the three community well-being providers which included the community well-being committees (CHCs), CHEWs, and CHVs. Nonetheless, the information disseminated to households on CHS was low or non-existent probably because of the inadequate training and facilitation provided to CHVs and poor publicity on the enactment of the program to the local community. Furthermore, there is little progress and attention given to its enactment. Therefore, this research aimed at assessing the factors affecting the enactment of CHS in Mogotio Sub County, Baringo, Kenya

1.3 Purpose/General Objective of the Research

The purpose of the study was to assess factors affecting the implementation of CHS in Mogotio sub-county, Baringo, Kenya.

1.4 Study Objectives

1. To determine the training capacity provided to community well-being volunteers in implementation of CHS in Mogotio Sub County.
2. To determine the participation of the county administration in the provision of resources for the implementation of CHS in Mogotio Sub-County.
3. To examine the level of community awareness on the implementation of CHS in Mogotio Sub-County.
4. To determine the challenges faced by community well-being volunteers and county administration in the implementation of CHS in Mogotio Sub County.

1.5 Research questions

1. What is the training capacity provided to the CHVs in Mogotio sub county?

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2. What is the role of county administration in the provision of resources for the implementation of the CHS in Mogotio sub county?
3. What is the level of awareness of the community on the implementation of CHS in Mogotio sub county?
4. What are the challenges faced by community well-being volunteers and County Administration in implementing CHS in Mogotio sub county?

1.6 Study Justification

A significant number of CHVs have dropped out because of lack of incentives (Rok, 2017). This had an impact on service delivery to rural households that required information on well-being care. CHVs would help in reversing the trends in wellbeing indicators as were stipulated in the Kenya Essential Package for Wellbeing (Rok, 2016). There is need for the successful enactment of CHS within the Mogotio sub-county well-being sector for the improvement of wellbeing indicators in Mogotio Sub-County (DHIS, 2018). The findings of the study identified gaps and areas of unmet needs, information and training gaps. Based on these, the study has made strategic recommendations for improved practice, policy enactment, and the county stakeholders to improve specific areas pointed out during this study. The study has also provided suggestions on better ways of improving sources of support and development of a policy that would strengthen Community well-being Volunteers engagement in the provision of well-being services not only in Baringo County but also in other Counties in the country.

1.7 Study Scope

The study was done in Mogotio Sub County which is also one of the six Sub Counties that form Baringo County. There were three wards and the study was carried out in mogotio ward it also had nine community units and twenty- three locations with forty- eight sub-locations.

1.8 Study Limitations

Respondents might not have provided accurate information due to lack of understanding of the questions which were written in English. The research was steered in three locations of the Sub- County because the area was vast and also due to inadequate financial resources, poor road network as well as issues of insecurity in some parts of the sub-county.

1.9 Delimitations

The researcher translated the questions in the local language for ease of understanding by respondents. The researcher used motorbike transport for large coverage to minimize cost and increase access to as many places as possible. The researcher also ensured that the sample population was a true representative of the target population.

1.10 Study Assumptions.

The research presumed that the required sample population would be available to precisely provide answers on the questionnaire. It also assumed that Household Heads (HHH) would provide relevant information necessary for the study. It was also assumed that the three locations studied provided a true and similar scenario to all the other parts of Mogotio Sub-County.

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1.11 Operational Definition of Terms

Communal well-being Approach-This is a tactic of delivering Kenya vital package of Wellbeing at the community level.

Community well-being Unit– it is the smallest administrative unit usually a sub- location with a population of 5000 people or has 1000 households.

Community-Based CHEW-This is the community well-being extension worker who works with CHVs in the community.

Communicable diseases- These are infectious diseases that can be transmitted from one person to another.

Community unit technical advisor- This is normally a community well-being extension worker

Facility-Based CHEW-This is the community well-being extension worker who provides well-being services at the wellbeing facility and receives referrals and wellbeing information from CHVs.

Household – These are people often a family who stay in one homestead and cook and eat food from one pot.

Household Head-this is the father, mother or a child above 18 years in case parents are not alive.

Incentives – these are the motivation that are provided to CHVs and CHCs and are either monetary or non-monetary

Non Communicable Diseases (NCDs)-These are diseases that cannot be spread from one individual to another.

Skilled birth attendant-This is a trained nurse, clinical officer or medical officer of wellbeing who conducts delivery.

Skilled delivery- This is delivery conducted by a trained wellbeing worker.

Unskilled delivery-This is delivery conducted by untrained or lay person.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section comprises the review of the literature on the objectives of the study including the theoretical outline, conceptual outline, knowledge gap, and summary of the review of the literature.

2.1 Training Capacity of Community well-being Volunteers

Community well-being Volunteers (CHVs) are selected by the community participants in a public meeting. The CHVs are then trained on the six basic modules which are mandatory for one to qualify as a Community well-being Volunteer. The training takes ten (10) days. The CHVs are to be trained on the second phase on seven technical modules based on the availability of resources.

The training offered to the CHVs would equip them with the essential skills required to be able to achieve their characters well such as: Identifying problems related to wellbeing and assessing to solve them, they also act as the link between the well-being facilities and the households, the CHVs provide wellbeing education to the households on key wellbeing practices, for example, safe maternal and child wellbeing, promoting hygiene environment, promoting good nutrition, seeking early treatment. The CHVs also do household registration to capture the wellbeing indicators in the households to prioritize on action points to be undertaken in solving the wellbeing problems. (RoK, 2005).

Malawi is one of the countries where the African Strategies for wellbeing (ASW) project conducted a literature review and in-depth studies to realize the impact of monetary and non-monetary incentives on the performance and retaining community well-being of employees in Africa. This country was chosen because it had a national cadre of state-funded CHWs and the mode of motivation at the moment being implemented by community well-being services (Asweto et al., 2016)

The 1978 meeting on the primary wellbeing care concept coincided with the initiation of CHS in Ethiopia (Perry et al., 2004). In Uganda CHVs are required to perform general tasks in all the main areas of primary wellbeing care. The tasks include; home visits, mobilizing

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the community to access and make use of the well-being services, community info, provision of well-being education, management of common infections and follow-up of pregnant women and newborns, and follow-up of hospital discharged patients and also a follow-up of those on long term treatment (RoU, 2010).

While most East and Southern African Region (ESAR) countries have brought down child mortality in the past two decades, it is reported that about a million children still die every year in this region mostly from diseases that could be prevented if only wellbeing services were made available (WHO, 2013). The wellbeing workforce for level one in Ethiopia comprised of CHVs, CHEWs and Wellbeing Development Army (WDA) volunteers. WDA Volunteers are not given any money but were provided with non- financial motivation that come in form of identification, capacity building, being awarded with certificates of participation and also recognized during community functions and celebrities (Crigler et al., 2011).

2.2.1 The role of County Administration in the provision of incentives to CHVs

For administration and organizations to adopt, enact and scale up community well-being programs, there is a need for the administration and organizations to prioritize and provide resources for the enactment of community well-being services. It is critical for the people who make laws and policies to know the significance of program design factors like the type of incentives as this may result to high performance of the CHWs and realize sustainability in wellbeing outcomes (Naimoli, 2013). Two approaches identified as key in pushing the agenda of vision 2030 of an effective and high-quality wellbeing care system were the devolution of funds and administration to the populations and counties and fluctuating the bias of national well-being from therapeutic to pre-emptive care (RoK, 2016). Sources of CHV motivation in Tanzania have been recognized at an individual, household, society as well as institutional set ups (Greenspan et al., 2013).

Community well-being Volunteer work is mostly volunteerism services. The CHVs use knowledge and skills they acquired during their training to solve challenges they face and also problems facing the household units and the society. The household and community members also provide extra form of incentive as they provide funds with other goods which include money, supply of commodities, and assisting in farming. Families and communities

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work well with Community well-being Volunteers. In the organizational levels, (the administration and donors motivate CHVs in terms of stipends, job provisions, and commodity provisions to support the monitoring of activities in the wellbeing facilities. Insufficient remuneration and commodity supply disappoint CHVs (Mpembeni et al., 2015). The community-based approach is designed in a way that is intended to capacity-build rural communities to enable accessibility analysis planning, enactment, and management of well-being and wellbeing-related development aspects to help them ensure that they subsidize successfully to the country's socio-economic development (RoK, 2013). Community well-being Volunteers (CHVs) do perform a vivacious role in terms of the provision of primary wellbeing care in Uganda. Many countries in the World depend on CHVs programs in enhancing access to wellbeing care and attainment of universal wellbeing coverage (Kuule et al., 2017).

2.2.2 Level of awareness of the community

The training provided to CHVs is not as comprehensive as the training for formally trained wellbeing employees. Nevertheless, CHVs differ within a country and also across other countries about the way they are recruited; trained, supervised, and extend of their work and type of remuneration (McMahon et al, 2013). In Malawi, Primary wellbeing care services are offered through community centers,public wellbeing facilities and community well-being units mostly in the rural areas where 86% of the rural populace live (GoM, 2014).

2.2.3 Challenges in implementing communal well-being approach

Formal Community well-being programs have been existing for many decades in many countries. One form is China's famous and successful barefoot doctors' program of the mid-1900s (mostly 1965-1981) which provided well-being care to rural villages where the doctors who were trained in the urban set up were not willing to provide wellbeing services in places with difficult accessibility. (WHO, 2008). During the third global human resource for the wellbeing (HRW) forum in Brazil in 2013, Kenya committed to 5 HRW commitments, which included; recruiting 40,000 Community well-being Extension Employees by 2017, a campaigner to counties to establish community well-being services by 2017, the establishing of operationalization of community well-being units from 2,511 units in June 2012 to 9294 units by 2017, establish a mechanism for community well-being

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insurance through community well-being insurance as a modality for motivating the community well-being volunteers by 2015 (RoK, 2013). Rwanda is among the few countries in Africa which have succeeded in meeting all the wellbeing-related Millennium Development Goals (MDG). An assessment of the Kenya Wellbeing policy framework conveyed an overall deterioration in wellbeing-related indicators, despite increased funding to the wellbeing sector. Rwanda trained CHVs on the identification and giving heath talks in the community on the prevention of Non-Communicable Illnesses (NCDs) Kenya also pledged to the global commitment of being able to achieve universal well-being coverage (UHC) and also meet the maintainable development goals (SDGs) which greatly depend on wellbeing services delivered at the community level (MDG Report, 2013).

2.3 Critical Review

The Community well-being Approach (CHS) was introduced in Africa as a means to improve access to primary well-being care services, particularly for underserved rural populations. However, the successful enactment of the approach has been hindered by a variety of factors, including political, socio-economic, and cultural issues. the enactment of the CHS in Africa is influenced by several reasons, Political instability, socio-economic challenges, cultural beliefs and practices, wellbeing system factors, community participation, and the policy and regulatory environment all play a role in the achievement or fiasco of the approach. Addressing these factors is crucial for the effective enactment of the CHS and the improvement of primary well-being care services in Africa. The Community well-being Approach (CHS) was introduced in Africa to mend admittance to primary well-being care services, particularly for underserved rural populations. The enactment of the CHS has been ongoing in many African nations for several years, and its impact has been mixed (Ngilangwa, and Mgomella, 2018; Pascal et al., 2021).

In some countries, the CHS has had a positive impact on well-being care delivery. For example, in Kenya, the CHS has led to increased access to well-being care services, improved maternal and child wellbeing outcomes, and reduced well-being care costs (Mash et al., 2020). In Ethiopia, the CHS has also been successful in improving access to well-being care services and reducing maternal and child mortality rates. However, in other countries, the enactment of the CHS has been hindered by various difficulties (David et al.,

2022). For example, in Nigeria, the CHS has faced challenges such as inadequate funding, poor infrastructure, and insufficient training for community well-being employees. These challenges have limited the effectiveness of the approach (Abdulmali et al 2016). Furthermore, the COVID-19 disease has further exposed numerous problems facing the enactment of the CHS in Africa. The pandemic has disrupted the delivery of well-being care services, and many countries have struggled to maintain the momentum of the CHS. Overall, while the CHS has had some success in improving well-being care delivery in Africa, there is still much work to be done to ensure its effectiveness. Addressing the challenges facing the enactment of the CHS, such as political instability, weak wellbeing systems, inadequate funding, and poor infrastructure, will be crucial for the successful enactment of the approach (Brey et al., 2020).

The Kenya Community well-being Approach was launched in 2006 as a means of delivering the Kenya Essential Package for Wellbeing, National Wellbeing Approach Plan (RoK, 2012). CHVs are important in providing accessible wellbeing care services, especially in densely populated areas and hard-to-reach areas in the community. The CHVs form part of the wellbeing care providers who are always the frontline team in the provision of PHC and provide essential services in an integrated well-being care system (GoM, 2013).

The Kenya Essential package for Wellbeing came up with a six-level cohort of well-being service endowment with level one being the municipal unit whereas level six is the referral hospitals. Community well-being volunteers are tasked with the responsibility of increasing access to well-being care for millions of people across Africa (WHO, 2013). Many countries are supported by partners to help them run CHS activities unlike Angola and Lesotho which support their CHVS entirely through money sourced domestically (Sharkey et al., 2014). The approach launched in 2006 was revised in 2013 since wellbeing service is a devolved function and the approach was revised between (2014-2019) when counties were then supposed to provide well-being care and also were required to implement other programs which included CHS (RoK, 2012). Many countries engage CHVs to work at the community level to promote wellbeing services in households (Gill et al., 2013). The community well-being approach is an effective means for improving wellbeing to promote development and achieving universal wellbeing coverage. A single CHV provides well-being care to a

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catchment population ranging from 200-2500 people and Populations more than this in most cases were put under a well-being center (WHO, 2012).

The Community well-being Approach launched in Kenya in 2006 was aimed at improving access to primary well being care services, particularly for underserved rural populations. The enactment of the CHS has been ongoing in Kenya for over a decade, and it has had a positive impact on well-being care delivery in the country (Wangalwa et al., 2012). Since the introduction of the CHS, there has been an increase in admittance to well-being care services, particularly in rural areas. This has been achieved through the deployment of community well-being employees who provide well-being care services to households in their communities. The CHWs offer a wide range of services, including wellbeing education, screening for common diseases, and referral services to wellbeing facilities. The CHS has also had a positive impact on maternal and child wellbeing outcomes in Kenya (Nzioki et al., 2017). According to a study published in the Journal of Global Wellbeing, the enactment of the CHS was linked with a significant decrease in maternal and neonatal mortality rates in Kenya. The study attributed this to increased access to well-being care services and improved well-being-seeking behavior among the population. Furthermore, the CHS has led to a reduction in well-being care costs for households. The CHWs provide well-being care services at a lower cost compared to formal well-being care facilities, and this has helped to reduce the financial burden of well-being care on households. However, despite these successes, the enactment of the CHS in Kenya has faced challenges. These challenges include inadequate funding, shortages of CHWs, inadequate training, and poor coordination between CHWs and formal well-being care facilities. These challenges have limited the effectiveness of the CHS in some areas. In conclusion, the enactment of the CHS in Kenya has had a positive impact on well-being care delivery, particularly in rural areas. However, addressing the challenges facing the enactment of the CHS, such as inadequate funding and shortages of CHWs, will be crucial for the continued success of the approach (Bhutta et al., 2005; Jillo et al., 2015).

Baringo County is situated in the Rift Valley region of Kenya and is one of the areas where the Community well-being Approach (CHS) has been implemented. The enactment of the CHS in Baringo County has had a positive impact on well-being care delivery, particularly

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in rural areas. One of the key achievements of the CHS in Baringo County has been the deployment of community well-being employees to provide well-being care services to households in their communities (Wangalwa et al., 2012). The CHWs offer a wide range of services, including wellbeing education, screening for common diseases, and referral services to wellbeing facilities. This has led to an upsurge in admittance to well-being care services in the county, particularly in difficult-to-get areas. The CHS also had a positive impact on maternal and child wellbeing outcomes in Baringo County. According to a report by the Ministry of Wellbeing, the enactment of the CHS in Baringo County has led to a significant reduction in maternal and neonatal mortality rates (Mutua et al., 2016). This has been accredited to improved admittance to well-being care services and improved well-being-seeking behavior among the population. Furthermore, the CHS has helped to reduce the economic burden of well-being care on households in Baringo County. The CHWs provide well-being care services at a lower cost compared to formal well-being care facilities, and this has helped to reduce the out-of-pocket expenditure on well-being care for households. However, the enactment of the CHS in Baringo County has also faced some challenges. These challenges include inadequate funding, shortages of CHWs, and inadequate training. Addressing these challenges will be crucial for the continued success of the CHS in the county.

In conclusion, the enactment of the CHS in Baringo County has had a positive impact on well-being care delivery, particularly in rural areas. However, addressing the challenges facing the enactment of the CHS, such as inadequate funding and shortages of CHWs, will be crucial for the continued success of the approach in the county (Wangalwa et al., 2012; Lee et al, 2022).

Mogotio is a sub-county in Baringo County, Kenya, and like many rural areas in Kenya, it faces difficulties in the establishment of well-being services. However, efforts have been made to improve access to well-being care services in Mogotio. One of the key strategies for improving access to well-being care services in Mogotio is the deployment of community well-being employees (CHWs) through the Community well-being Approach (CHS). The CHWs provide well-being care services to households in their communities, including wellbeing education, screening for common diseases, and referral services to wellbeing

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facilities. This has helped to increase access to well-being care services in Mogotio, particularly in difficult-to-access areas. In addition to the CHS, there are also several wellbeing facilities in Mogotio, including dispensaries and wellbeing centers. However, these facilities face challenges such as inadequate funding, shortage of staff, and inadequate medical supplies and equipment. These challenges limit the quality of well-being care services provided in these facilities. Furthermore, the COVID-19 disease has influenced the provision of well-being care services in Mogotio, as in other parts of the world. The pandemic has disrupted the delivery of well-being care services and has led to a reduction in the utilization of wellbeing facilities due to fear of contracting the virus. While efforts have been made to improve access to well-being care services in Mogotio, the sub-county still faces challenges in the delivery of quality well-being care services. Addressing these challenges, such as inadequate funding, employee shortage, and inadequate medical supplies and equipment, will be crucial for improving the provision of well-being care services in Mogotio (Wangalwa et al., 2012; Lee et al, 2022).

2.4 Theoretical framework

2.4.1 Vroom's Theory

This theory was developed in 1964 by Vroom. It suggests that people can be motivated to do work that can take them to desirable outcomes and which can be both of inherent and extrinsic prizes. The theory explains that gratification in any engagement follows the achievement of rewards. This translates that people are content and motivated with any undertaking which leads to them getting desirable rewards. It further explains that people will do work efficiently when their desired inherent and extrinsic prizes are contingent upon good act.

The theory emphasizes that persons will be interested to provide their best when rewards are given based on performance which is good. The theory is relevant to this study because it touches on motivation and rewards issues which are key factors in the success of any activity to be undertaken. This means that if the community well-being volunteers, community well-being committees, and community well-being extension employees who are tasked with implementing the community well-being approach are provided with incentives to motivate them and also recognized by rewarding them for the good work they do they may perform

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better which will lead to greater achievement in the work they undertake(vroom,1964).

2.5 Conceptual framework

The concrete framework (Figure 2.1) shows the direction of the independent to the dependent variables. This implies that the enactment of the community well-being approach by CHVs is a function of various factors including education level, motivation of CHVs, creation of awareness to household members, economic status of households, and policy guidelines on the provision of quality wellbeing care to communities.

Independent variables

Dependent variable

CHVs Training Capacity and Challenges
- Basic Module
- Technical Modules
- Other health topics
- Lack of support

County Government Participation and challenges
- Providing incentives to CHV.
- Providing funds for CHS implementation.
- Low funding for CHS

Level of community awareness
- Participation in planning, dialogue and health actions days

Policy guideline on community health care

Intervening variables

Quality of community health services

Figure 2.1: Conceptual Framework

2.6 Knowledge Gap

Funding of CHV program practiced in other countries like Lesotho and Angola (Vareilles et al/. 2017; Seutloali et al., 2018) indicated that it is a good practice that enhances the sustainability of CHS. Most African countries including Kenya depend on donors to fund CHV program and the sustainability of the program becomes a problem because donors leave upon expiry of their contract or when the funds reduce. Therefore, the Lesotho and Angola practice should be adopted for effective enactment of CHS in Baringo and other counties in Kenya.

In the organizational level the administration and donors motivate CHVs in terms of stipends, employment, material support, training and supportive supervision. The Ethiopian administration implemented programs including community well-being approach which are geared towards shifting the wellbeing systems focus from predominantly curative to preventive wellbeing services (Crigler et al 2004). The county administration of Baringo and the national administration has been putting more money on curative services and allocate little money on preventive wellbeing services which are always evident from the budget they make in the department of wellbeing. The county administration needs to adopt the Ethiopian way of prioritizing preventive services instead of the current preferred curative services in the county. It is likely that due to low incentive provision to the CHVs thus might have contributed to the slow enactment of the community well-being approach in the study area. Therefore, this study will focus on determining the factors affecting the effective enactment of the community well-being approach in Mogotio Sub County of Baringo, Kenya and the entire literature review is summarized in Table 1.

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Table 1: Summary of literature review

AUTHORS	THEME	GAP
RoK, 2012 RoU, 2010	WellbeingPolicy Enactiment	No devolution aspect on wellbeing service provision
Perry et al, 2004 Crigler et al, 2011Green span et al, 2013Asweto et al, 2016 Mpembeni et al, 2015	Motivation of community well-being service providers	Inadequate on motivation to community well-being service providers
GoM, 2014 WHO, 2008	Level of community wellbeing Approach awareness	Inadequate on awareness Creation to CHVs,CHEWs And HHHs

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CHAPTER THREE

METHODS AND MATERIALS

3.0 Introduction

The area of the study, design of the study, targeted population, determination of the sample size, sampling procedure, reliability and validity, ethical issues, plan for data analysis, and presentation plan.

3.1 Location of the Study

The research was done in Mogotio Sub County, Baringo County, Kenya.The reason why I chose Baringo was beacause it was implementing community well-being approach program and further more why I preferred Mogotio SubCounty was because it had old community units and also new community units as this would provide a wider perspective of community well-being approach enactment. The County had a population of 754,014 persons, 150,803 households, 1,946 villages, 348 sub locations, 30 Wards and 6 Sub Counties including Mogotio Sub County which was the study area. Mogotio Sub County had a population of 82,734 persons 16,547 households (HHs) and 336 villages. Mogotio sub-county borders Nakuru County, head office is in Mogotio town which was 40 km from Nakuru town along Nakuru – Marigat highway. The status of wellbeing facilities and organizational structure were as provided in Table 2 below. The study was conducted in three locations in Mogotio ward namely: Ngubereti location, Koitebes location and Sirwa location. Ngubereti was 55km from Nakuru Town along Mogotio – Marigat road and it was 15km from Mogotio town. Koitebes was 75km from Nakuru town along Emining-Eldama Ravine Road. Sirwa was 95 km from Nakuru town accessed through Kimngorom – Sirwa Tarmac road.

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Table 2: The status of wellbeing facilities and organizational structure

Wellbeing facility	Established community well-being unit	Number of Community well-being Volunteers	The number of Community Heath Committees.	The number of Community well-being Extension Employees.
Sirwa Dispensary	Sirwa Community well-being Unit.	25	13	2
Koitebes Dispensary	Koitebes Community well-being Unit.	25	9	2
;lmk,				
Kiptoim Dispensary	None	0	0	0
Ngubereti Dispensary	Ngubereti Community well-being Unit	25	9	2
Mogotio Sub County	Mogotio Community well-being Unit	25	9	3
TOTAL	5	125	51	12

Source DHIS, (2018)

3.2 Design of the Study

The research employed a cross-sectional study design in collecting primary data. Quantitative and qualitative information was collected by administering questionnaires to the respondents in the three locations. The respondents included household heads, CHVs, CHEWs and key informants. Focus Group discussions (FGDs) and interview schedules was also conducted to get in-depth information relevant for the study from the community leaders.

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3.3 Target population

The targeted populace included; Community members, Community well-being Volunteers, Community well-being Extension Employees, County Wellbeing Officers, office of Chief Officer of Wellbeing, Office of County Executive Committee. The study was carried out in three locations in Mogotio ward, namely; Koitebes Location, Ngubereti Location and Sirwa Location. Koitebes location had a population of 2140 persons and 434 households, Ngubereti with a population of 4347 and 926 households and Sirwa with a population of 5919 with 1050 households as show in Table 4 below (DHIS, 2018).

Table 3: Population of the study locations

Location	Target Population	Household Heads
Koitebes	2140	434
Ngubereti	4374	926
Sirwa	5919	1050
TOTAL	**12,406**	**2410**

Source DHIS, (2018)

3.4 Determination of the Sample Size and Procedures for Sampling

3.4.1 Determination of Sample Size

The size of the sample was determined using Mugenda and Mugenda (1999) formula:

$$N=\frac{z^2pq}{d^2}$$

Where:

N=Anticipated sample size

z= the standard normal deviate at the required confidence level $(1.96)^2$.

p= the percentage in the target population projected to have features being measured. The study used Community Unit coverage which was 40%.

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40%=0.4.

q=I-P

d=Level of statist[ical connotation set (0.05),

Calculation.

$$N= \frac{(1.96)^2 \times 0.40\ (1-0.40)}{(0.05)^2}$$

$$N= \frac{(1.96)^2 \times 0.40\ (1-0.40)}{(0.05)^2}$$

$$= \frac{(1.96)^2 \times 0.40\ (0.60)}{0.0025}$$

$$= \frac{3.8416 \times 0.24}{0.0025}$$

= 368.7936

= 369

To arrive at the number of household heads who took part in the study, Andrew Fishers method of 1998 for the study population less than 10,000 was used.

Formulae calculation

$$Nf = \frac{n}{1+n/N}$$

Description

Nf = the anticipated size of the sample

n= Sample size calculated 369

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1 = Constant

N= the estimate population size (2410 households)

Calculation

$$Nf = \frac{n}{1+n/N}$$

$$= \frac{369}{1+369/2410}$$

$$= \frac{369}{1+0.1531}$$

$$= \frac{369}{1.1531}$$

= 320

Sample Size Distribution

The distribution of target population(household heads) is shown in Table 4 below which also show the sample size calculated per location using the proportionate percentage 13.278% arrived at after dividing the saple size (320) over the total household heads (2410) targeted multiplied by 100% thereby giving sample size for ofeach of the three locations.

Table 4: Sample Size Distribution

Location	Target population	Proportionate percentage	Sample
Koitebes	434	13.278%	58
Ngubereti	926	13.278%	123
Sirwa	1050	13.278%	139
Total			**320**

Source: The Researcher

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Distribution of Key Informants

The distribution of key informants is shown in Table 5 below per each category after applying 50% to arrive at the sample size for each category.

Table 5: Distribution of Key Informants

Category	Target	%	Sample
CHMT	15	50%	8
CHEWS	10	50%	5
CHVs	75	50%	38
Total			**51**

Source: The Researcher

3.4.2 Procedure for Sampling

Sampling was done proportionally whereby 13.278% of the total household heads in each location was sampled. A random sampling which was simple random was adopted to select household head participants in each location and purposive sampling was used to select key informants. The investigator administered the questionnaire to the selected participants. The respondents were provided with questionnaires for collecting the data. An interview schedule was used to collect data from key informants (CHMT, CHEWs and CHVs). Likert scale (1 = No influence, 2= Small influence, 3= influence which is medium, 4= influence which is high, influence which is very high) was used in ranking the strength of the roles by the community well-being volunteers and the challenges faced by the community well-being volunteers and the county administration in the enactment of community well-being approach.

3.5 Research Instruments

A structured questionnaire with a set of open ended and closed ended questions was presented to the respondents to obtain answers. The researcher administered the questionnaire to household heads and interview schedule was also used on key informants

whereby the researcher asked some of the technical questions in regard to the study objectives.

3.6 Testing for Validity and Reliability

Piloting of the data collection tools was done prior to the administration of the same to study area. This was done in Emining Ward, Emining Location, by administering the same questionnaire to selected 30 respondents. This pre-test actually gaged the suitability of the questionnaire, in terms of language, sensitivity to the cultural beliefs and norms of the local community. The researcher used the responses to amend the questionnaire to make it reliable and valid as an instrument of data collection.

3.7 Data analysis and presentation

The data was executed by use of the Statistical Package for the Social Sciences (SPSS) computer software version 21. The results were presented by descriptive statistics (bar graphs, pie charts and frequency distribution tables). Inferential analysis was employed to reveal an association between independent variables and dependent variables.

3.8 Ethical Consideration

The researcher sought clearance from the Ethics Review Committee of Mount Kenya University. A research permit from National Commission for Science, Technology and Innovation (NACOSTI) was also sought. The participants were given clear and sufficient information on what the research entails before interviewing and administering the questionnaire to them. They were assured of confidentiality on any information they would provide. To ensure anonymity and confidentiality, numbers were used to identify households instead of names of persons. No respondent was coerced to answer questions they may not wish to answer.

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CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This section contains the results and discussions of the study which have been done objective-wise.

4.1 Response Rate

As per Bird (2009), this is the rate which is the same as the number of people the questionnaires would be presented to being divided by the total digit of people in the whole sample. Confidentiality was assured to the respondents for all the information they would give as shown in gigure 4.1 below. Babbie (1990) affirms that a response rate of 70% and above is very good for analysis. This showed that 87.4% rate of response was suitable for data analysis.

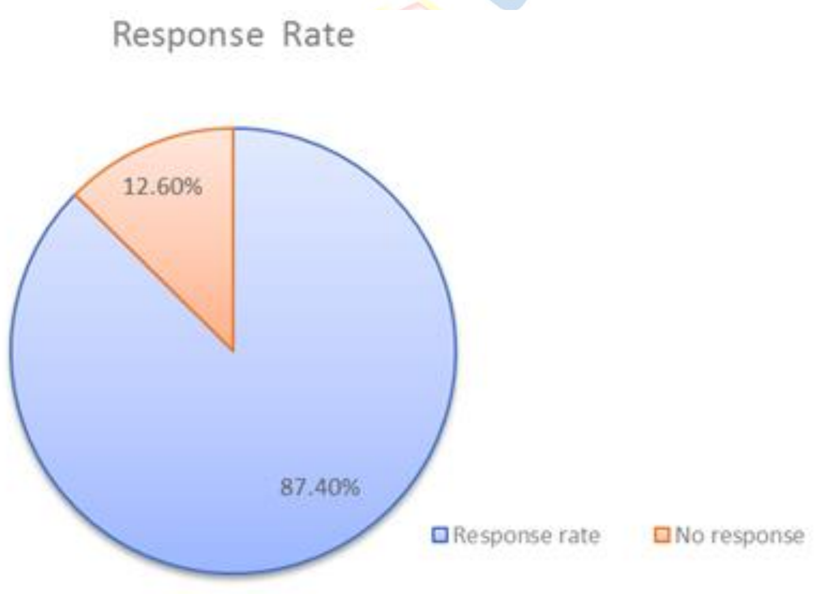

Figure 1: Response rate

Source: Researcher (2019)

4.2 CHARACTERISTICS OF COMMUNITY WELL-BEING VOLUNTEERS

4.2.1 Gender of CHVs

The findings from this study (Figure 4.2) show that 52% of the community well-being volunteers were females while 48% were males. This indicated that the majority of community well-being volunteers within the study area were females. Even though females dominated the community well-being volunteer workforce, the difference was within the two-third gender rule as outlined in the Kenyan constitution (Kenyan Constitution, 2010). The current study was therefore consistent with findings of other studies that indicated high number of female Community well-being Volunteers, for instance, a study done by Kuule (2013) showed that female community well-being volunteers were 65%, whereas their male counter parts were 35%, indicating that even in rural Uganda majority of the CHVs were females. This would further imply that many communities prefer recruiting female communal well-being volunteers probably because they believe that they would offer better community well-being services and in most cases they may work for a longer period compared to the male community well-being volunteers who drop out quite easily as they do not withstand the challenges which face general enactment of community well-being approach. The results of this study also indicated that 82% of the community well-being volunteers were responsible for more households than the recommended number of households of between 20-30 households. Whereas in Kuule (2013) study, 37% of the communal well-being volunteers each took care of more than 20-30 households, implying that the majority of the community well-being volunteers from the study area were allocated more households than their counter parts in rural Uganda of whom only 37% were each responsible for more households than the recommended 20-30 households. This implies that community well-being volunteers in the study area had more workload and bearing in mind that they were not provided with monitory incentives, thus the CHVs were sacrificing a lot as they valued the wellbeing of their fellow community members(Chandra et al 2019).. For example, in Sirwa community unit, every CHV was responsible for 42 households which meant that a CHV couldn't visit all households within one month. This was evident from the results which revealed that household visitation was 89%, 93% and 83% for Sirwa, Ngubereti and Koitebes community units respectively.

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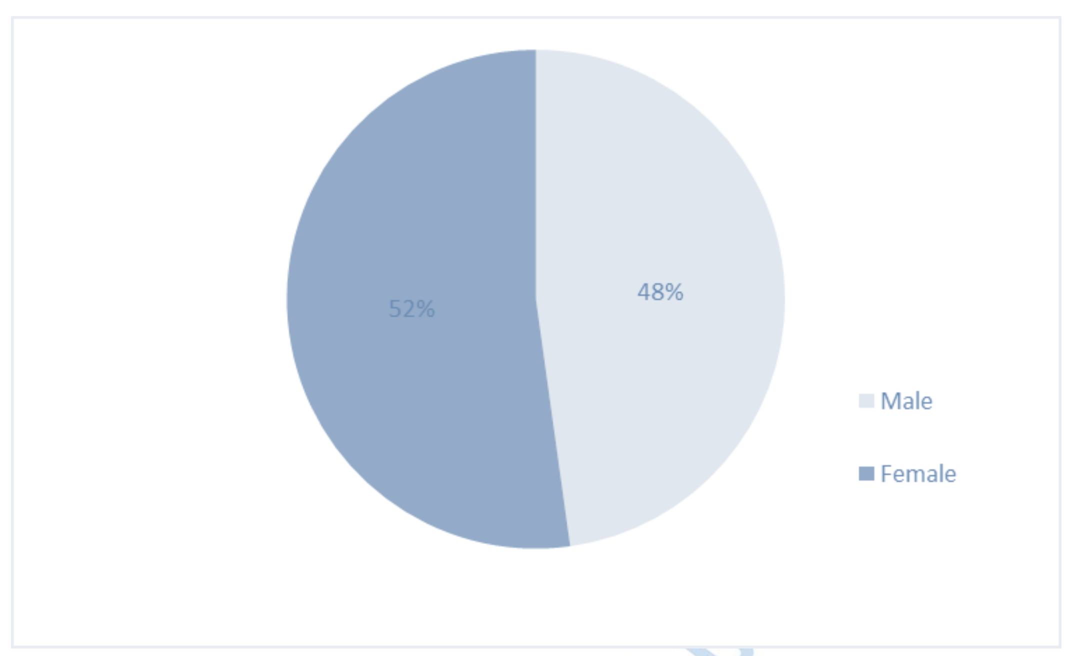

Figure 2: Gender of community well-being volunteers

4.2.2 Age of community well-being volunteers

Majority (91.3 %) of the community well-being volunteers were between the age of 25 years and 45 years and only 7.7 % were aged between 46 years and 59 years (Figure 4.3). This indicated that the age of community well-being volunteers was normally distributed. It also implies that most community well-being volunteers were middle-aged meaning that they had the experience and energy necessary for the enactment of the community well-being approach. This would also imply that well-being service delivery may be sustained because the age category in which the majority of community well-being volunteers are, would sustainably provide the required well-being services for long period. The age of community well-being volunteers is important and should be considered when recruiting them for it is a critical factor in the sustainability of the community well-being approach program. The age category of between 25 years and 45 years would be better placed to handle community well-being approach activities because most of the activities involve maternal and child well-being and also being the child bearing cohort. Similarly, people aged below 25 often abandon their responsibilities, especially when they get alternative employment and hence not reliable for long term engagement. Therefore, this age of between 25 years and 45 years is preferable

for the optimum enactment of the community well-being approach. Nevertheless, the study results also showed that there were neither no respondents in the age of 18 years to 24 years nor the age of between 60 to 70 years. This implied the existence of active generation that would robustly help in the enactment of community well-being approach activities. The results of this study were consistent with the study by Kuule, (2013) within rural part of Uganda which also indicated that majority (61.7%) of the community well-being volunteers were under the age of 45 years. This implies that CHVs in rural Uganda and in the study area consisted of young adults who were still energetic and able to implement the community well-being approach with the required strength to ensure that the required well-being outcome would be achieved within a shorter period.

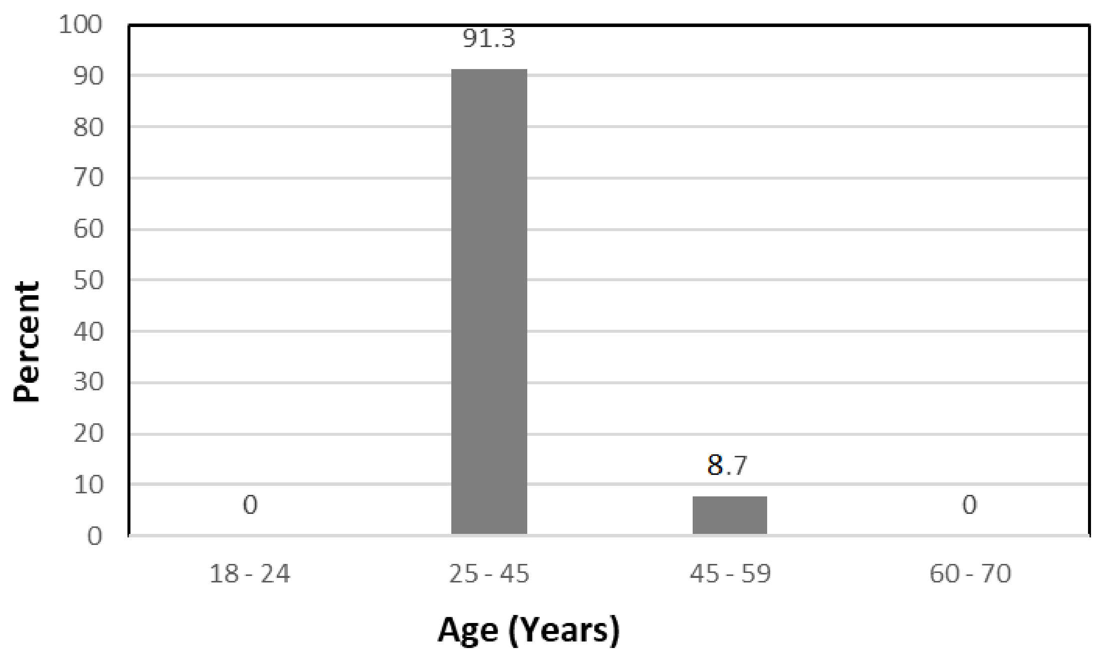

Figure 3: Age of CHVs

4.2.3 Community well-being Volunteer's Level of Education

The study findings (Figure 4.4) show that (52.2%) of the CHVs had achieved secondary education level status, 26.1 % had tertiary education status whereas 21.7 % were of primary education status. The fact that more than half of the CHVs had secondary school education qualifications meant that they could understand and handle wellbeing issues easily and also use the skills they gained during training especially on the basic modules to implement a

community well-being approach in a better way because they would easily comprehend the issues of wellbeing especially when communicating and disseminating wellbeing information to community members. The study findings were the same with that of Sylvester (2020) which indicated that the majority (56.7%) of the CHVs had achieved primary and secondary education. The study results also agreed with that of Nelima (2018), which indicated that the education level of community well-being volunteers was vital in disseminating well-being messages to the community. The CHVs work hard to bring the expected behavior change among households in their allocated catchment area despite experiencing numerous challenges which included lack of compensation which featured as one of the demotivating factors for community well-being volunteers. Indeed, the ministry of wellbeing have been partnering with Non-Administrational Organizations involved in wellbeing matters and development program to provide community well-being volunteers with a small stipend. The inadequate support to CHVs has resulted to them spending little time in rendering the services, a situation that compromises the quality of engagement with household members (Nelima 2015).

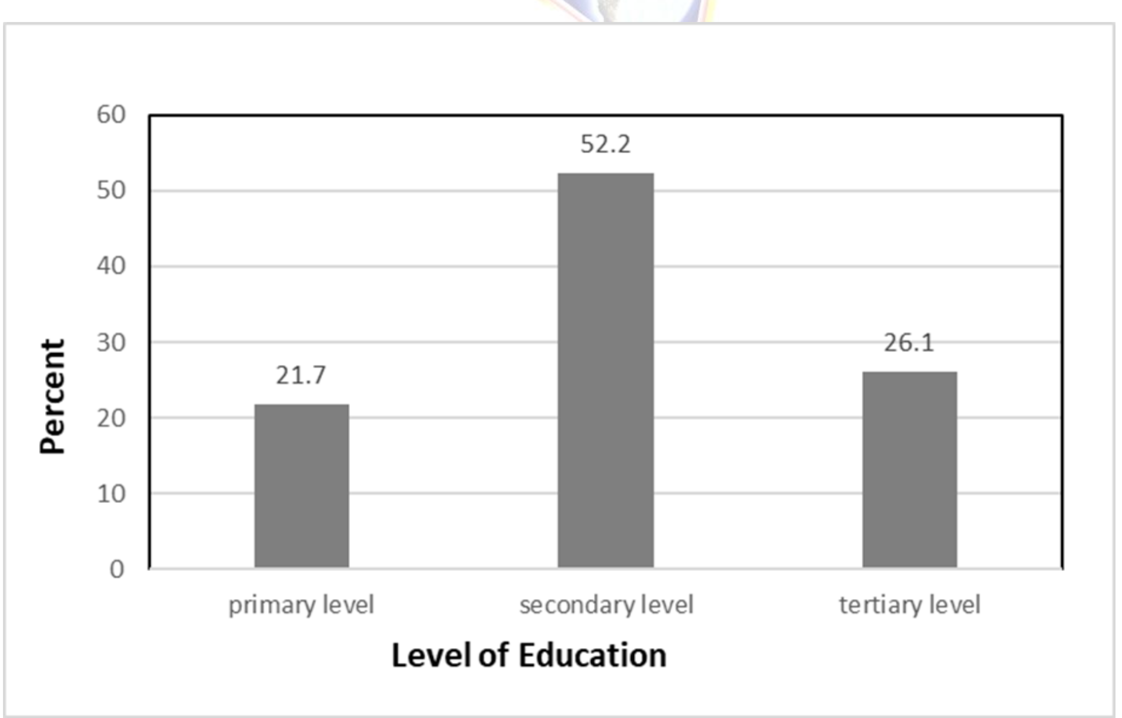

Figure 4: CHVs Education Level

4.2.4 Occupation of community well-being volunteers

The study findings (Figure 5), showed that the majority (45 %) of the CHVs had no employment,35 % were involved with some business and 20% earned their living by doing some little chores. This is a true indicator that most of the community well-being volunteers who were engaged in the enactment of the community well-being approach had no employment. This implies that their living standards were low and therefore they needed help from the county administration and the community in terms of monetary and material assistance in order to make their ends meet, considering that they were not being provided with stipends. On the other hand, those who engaged in business and casual work could not have had time to perform their roles as community well-being volunteers which would affect the enactment of CHS in the long run. These may contribute to challenges that affect effective enactment of CHS in the community. Insufficient income to CHVs may demotivate them in promoting behavior changes among communities in the enactment of Community well-being strategies in Counties (Aseyo et al., 2018).

Figure 5: Occupations of CHVs

4.2.5 Duration of community well-being volunteers

According to Figure 6, majority (60.8 %) of the CHVs who partook in the research indicated to have served for the duration of between 7– 9 years followed by 30.5 % of them who had served between 1–3 years whereas only 8.7 % had been serving for between 4–6 years. This revealed that community well-being volunteers had the relevant experience for the enactment of the community well-being approach. It is also evident that there was a lot of disparity in the duration of service for the community well-being volunteers despite working in the same community unit. This could be the reason why there was no uniformity in the computation of data during quarterly data review meetings. It also means that there could have been rapid drop out of community well-being volunteers which was confirmed by the Community well-being volunteers who had served for the lesser period for they were selected to replace those who ceased to work, indicating they had not been trained especially on the basic modules. This may compromise the level of enactment of the community well-being approach at long run due to lack of relevant skills among a number of CHVs required in performing the activities competently. Nevertheless, this result indicates that majority of the community well-being volunteers had enough experience to implement the community well-being approach satisfactorily.

This result showed the significant role played by the CHVs in providing well-being care services at the household level, which was in deed in agreement with world wellbeing organization WHO (2018) affirmation that community well-being volunteers globally were engaged as a low-cost carder that provide well-being services in communities which experience difficulties in getting wellbeing care services from the mainstream wellbeing institutions. Through the study, it was noted that there was an increase in their uptake in the recent years after the World Wellbeing Organization [WHO] began to promote wellbeing oriented training or in other words incorporated skillful well-being care and other basic modalities to community well-being volunteer's workload (WHO, 2018). Community well-being extension employees (CHEWs) were paid salary whereas community well-being volunteers who were seen to be performing almost similar task were not paid but at times given incentives or some little financial support. Community well-being volunteers do not have clear employment approach and neither are they given assurance on retaining their jobs, (Mohajer and Singh, 2018)

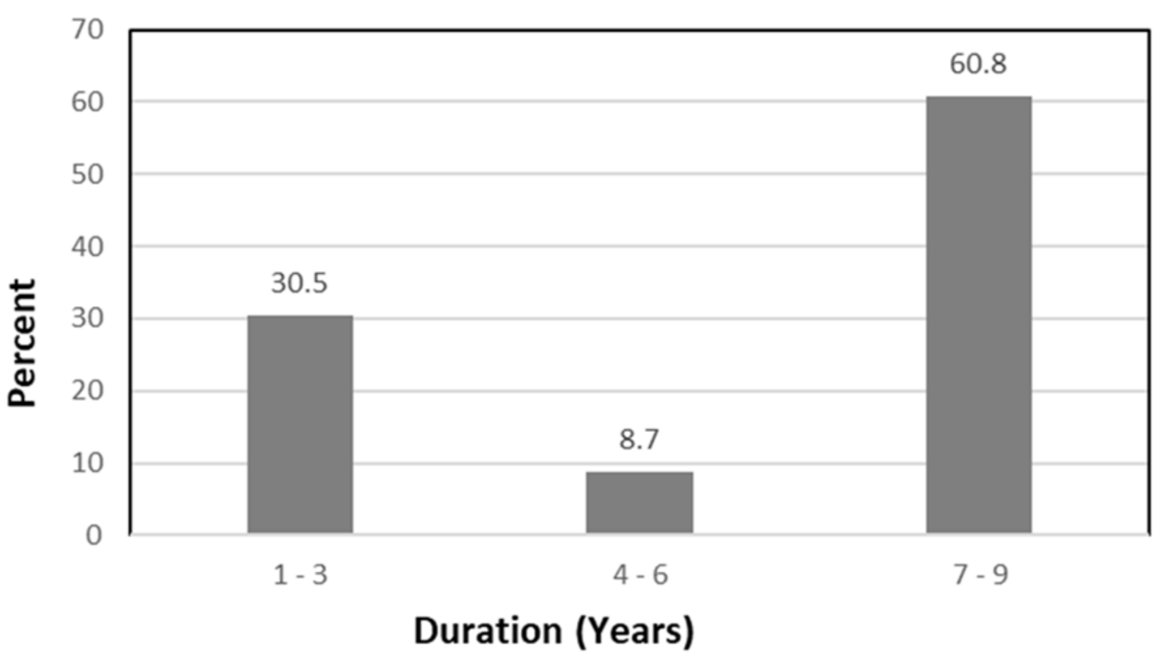

Figure 6: Duration as CHVs

4.3 Characteristics Of Family Heads

4.3.1 Gender of Family heads

The results (Table 6) show that 51% of the household heads from the 3 locations were male whereas 49% were women. This implies that the same proportions of both men and women participated in the study, indicating that both genders are equally involved in the enactment of CHS. This also meant that all genders were assigned the CHV role and this would lead to wide acceptance and ownership of the community approach program at the family level. Such findings were in contrast with the results of Kuule et al. (2017), whose findings showed that 65% of respondents were female and only 35% were male.

Table 6: Show the gender of the household participants in the three location

Community units	Male	Female
Sirwa	71	68
Ngubereti	70	53
Koitebes	22	36
Total	**163**	**157**
Percentage	**50.94%**	**49.06%**

4.3.2 Age of the household participants

The findings (Table 7) indicated that (45%, 53% and 53%) of the household respondents in Sirwa, Ngubereti and Koitebes locations respectively were aged between 25 and 45 years. The young participants were young adults (18-25 years) and the old (60-70 years). The results imply that the majority of the responses were obtained from young adults who may be more knowledgeable on modern well-being issues. This result may also portray that enactment of the community well-being approach would be done by the more energetic household heads. This would result to the completion of the activities within the right time and well-being outcomes may be realized in a shorter period because the middle-aged members of the community are known to have the passion to implement the activities of the program. It also implies that young members of the society are actively involved in the enactment of the community well-being approach and could also mean that these young people would be relied upon to steer forward the enactment of the community well-being approach and as such, they would play key roles in the operationalization of community units and also the sustainability of the community well-being approach. The research results are in agreement with the study by Kuule (2017) in Uganda which indicated that the respondents were also young adults aged below 36 years.

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Table 7: Categories of age of the household respondents in the study locations

Years	18-24	25-45	46-59	60-70
Sirwa	10%	45%	27%	18%
Ngubereti	10%	53%	27%	10%
Koitebes	2%	53%	36%	9%

4.3.3 Education level of household heads.

The results (Table 8) show average that (46%) of the household participants had a primary level of education whereas 36% had attained secondary education and only 18% had acquired a tertiary level of education. This implies that the community may have low level of understanding on well-being issues. This low level of education may have contributed to the challenges the community well-being volunteers encountered during their work as some of the community members showed a lot of ignorance and were not willing to execute interventions to address certain well-being problems as were advised or recommended by the community well-being volunteers. The low education status may also lead to misunderstanding of some of the fundamental well-being matters which may be essential for the enactment of community well-being approach in the study area which was also in agreement with the findings by (Aseyo et al., 2018), which stated that education level of the household heads is critical in the dissemination and understanding of wellbeing info and hence the low education level in the study area may hamper the perception of the importance of community well-being approach. For example, promotion of good nutrition and at the same time advocating for the wellbeing of the under privileged in the society with intention of improving wellbeing services and providing wellbeing information to the people making policies and also make informed decisions that facilitate referral of clients to wellbeing facilities for better management (Aseyo et al., 2018)

Table 8: Level of Education of HH Participants as per the location of the study area

Community unit	Primary Education	Secondary Education	Tertiary Education
Sirwa	49%	34%	17%
Ngubereti	41%	41%	18%
Koitebes	48%	31%	21%
Mean	46%	36%	18%

4.3. ,4 Occupation of the household respondents

It was evident (Table 9) that more than 33 % of household head participants were not employed and hence had no workable income. Sirwa and Koitebes Locations were the most affected by the unsustainable source of income (62% and 57% respectively). This was because of the interior and remote location of the two Locations where employment opportunities were minimal. The households therefore could not get enough time to implement community well-being activities as they struggle to make ends meet. The fact that many households did not have reliable source of income explains well why community well-being volunteers pointed out that one of the challenges they experienced when visiting households was the demand for subsidies by the household members. The findings from this study are in treaty with the findings of a study undertaken by Aseyo et al., (2018), which affirmed that if there is no source of income then this affects the acquisition or provision of the basic well-being requirement such as drugs and payment of hospital bill. It will also affect the accessibility of wellbeing care, increased screening of clients, enhanced communication among the community and well-being care employees and improved adherence to well-being recommendations (Aseyo et al., 2018).

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Table 9: The occupation of the household respondents

Community units	Employed	Not employed	Casual	Business person
Sirwa	12%	30%	32%	26%
Ngubereti	21%	42%	8%	29%
Koitebes	26%	28%	29%	17%
Mean	19%	33%	23%	24%

4.3.5 Knowledge of the household heads respondents on CHS

The research findings (Table 10) indicated that the majority of the household participants in Sirwa, Ngubereti and Koitebes knew of the existence of community well-being approach program. These results showed that 91% of household heads in Sirwa location confirmed that they knew what the community well-being approach entailed and another 90% also said that they were aware of the program in Ngubereti location and 86% of the household heads were aware of its existence in Koitebes location. Furthermore, 9%, 7% and 14% of the household heads in Sirwa, Ngubereti and Koitebes locations respectively had heard of the program but they said they did not know what it was all about despite the existence and enactment of the community well-being approach in the community since its establishment in 2012. This implies that more resources need to be used to sensitize the community on the benefits of the community well-being approach and owning of the program for sustainability purposes in the community.

Table 10: Knowledge of the respondents on existence of the CHS

Community units	Yes	No	Don't Know
Sirwa	91%	9%	0%
Ngubereti	90%	7%	3%
Koitebes	86%	14%	0%

4.3.6 Awareness of the household heads on the existence of CHVs

It was evident (Table 11) that majority of the participants knew their community well-being volunteers, with 94% of the respondents in Sirwa confirming that they actually knew their

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community well-being volunteers, another 94% of the households said that they were aware who their community well-being volunteers were and 85% of them revealed that they even knew their community well-being volunteers by name. It was also evident that 6% of the households did not know about their community well-being volunteers within Sirwa location, same to 6% in Ngubereti and 15% in Koitebes location. This implies that community well-being volunteers had good relations with their community members which meant that such interaction would make the enactment of the community well-being approach easier and well-being outcome may be achieved within a shorter period. Similarly, from the household heads who said that they did not know their community well-being volunteers, it was implication that may be the community well-being volunteers were not active and therefore they rarely visited the households. Therefore, enactment of the community well-being approach would be easier since the majority of the household members knew the existence of the community well-being approach and the CHVs and hence proper policies need to be put in place similar to the way Malawi administration adopted the National community well-being volunteer policy of 2015, which entrenches communal well-being approach in the national wellbeing sector policy to guide in the enactment of community well-being approach program and provide for more opportunities for the community well-being volunteers (RoK, 2015).

Community well-being employees can provide essential well-being care to rural households and urban slams areas with low well-being care coverage. Active community well-being volunteers are good promoters of adequate nutrition, general environmental sanitation hygiene and linking households to essential well-being care-based services. Much of Kenya the Kenyan population (75%) live in countryside areas, indicate that Kenya is a global well-being workforce crisis nation since for every 10000 persons there are 2 doctors and 9 nurses/ midwives in service (WHO, 2014).

The research findings revealed that community well-being volunteers could be relied upon to deliver well-being messages to households. It also showed that the community well-being volunteers were very committed and the well-being outcomes were expected to improve. The project aimed to train and facilitate community well-being volunteers to provide well-being services as they visited households. The evaluation of the project in 2013 indicated

that mothers who were visited by community well-being volunteers were 5.1 times more likely to receive postnatal care services when equated to other mothers who did not encounter community well-being volunteer visitations (WHO, 2015).

The study results also showed that community well-being volunteers were really known and familiar within the households, in fact, the community well-being volunteers were known even by their names. This made them to be easily allowed to enter the homesteads and deliver well-being messages, which included well-being education. Such results were consistent with the results of the study done on general community perception of community well-being volunteers on chronic disease management which also showed that community well-being volunteers do link wellbeing facilities and the community and also through well-being education they ensured diseases prevention and also facilitated de-stigmatization of patients living with terminal illnesses within the community (Rachlis et al., 2016).

Table 11: Awareness of households on existence of community well-being volunteers

Community units	Aware	Not Aware
Sirwa	94%	6%
Ngubereti	94%	6%
Koitebes	85%	15%

4.3.7 Responses of household heads on CHVs visitation to households

The results (Table 12) showed that the majority of the households had been visited by communal well-being volunteers. From this result 89%, 93% and 83% of the household heads in Sirwa, Ngubereti and Koitebes community units respectively confirmed that they had hosted their community well-being volunteers severally. Such occurrence was impressive for this would mean that well-being care services were rendered in the community, which would also mean that the well-being status of the community might improve over time. It was also realized that over 80% of households across the three locations were appreciating visitation by community well-being volunteers. However, it is also important to note that quite a sizeable number of households were not visited by their community well-being volunteers as were demonstrated by the 11%, 7% and 17%

households in Sirwa, Ngubereti and Koitebes locations respectively. This implies that community well-being volunteers were either not active or they might had dropped out, indicating that these households did not fully benefit from services normally offered by CHVs. Therefore, the results were consistent with a study on community well-being volunteers which was undertaken in Solomon Islands. This study affirmed that their dropout was due to the poor remuneration and lacking support from even their families, which made it difficult for them to perform their roles effectively. The enactment of the community well-being approach in Bangladesh by CHVs was also not successfully achieved, this was attributed to luck of support from their families which did not approve of their assignments and also the fact that lack of adequate remuneration for the wellbeing service they render at the households. Motivation and retention of community well-being volunteers is paramount as it impacts on the cost-effectiveness and also the sustainability of the community well-being volunteers program across many countries (Oyore et al., 2013).

Table 12: Responses on CHVs visitation to households

Community units	Visited	Not Visited
Sirwa	89%	11%
Ngubereti	93%	7%
Koitebes	83%	17%

4.3.8 Household heads responses on involvement on dialogue and wellbeing action days

The results of the study (Table 13) show that 28% of the households in Sirwa location were involved and participated in the dialogue and wellbeing action days. It also showed that 72% of them participated in the two community engagements and that 60% of the household heads were involved in the preparation and participation of the dialogue and wellbeing action days. However, 72%, 26% and 38% of the household heads (HHH) in Sirwa, Ngubereti and Koitebes locations respectively were not involved in the two community functions. It was also evident that more of the community members were involved in the two community activities in Ngubereti and Koitebes locations compared to the dismal number of household heads in Sirwa location which were involved in the dialogue and wellbeing action days. This

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was also an indication that community participation was relatively low in Sirwa community unit which suggest that community well-being volunteers and community well-being extension employees were not active in that location as compared to their counterparts in Ngubereti and Koitebes community units where more than half of the households confirmed to be involved in community dialogue days and wellbeing action days.

Table 13: Household responses on involvement on dialogue and Wellbeing Action days

Community units	Yes	No	Don't know
Sirwa	28%	72%	0%
Ngubereti	72%	26%	2%
Koitebes	60%	38%	2%

4.3.9 Household head's responses on planning community well-being approach

The findings (Table 14) showed that more than half of the participants in each of the three locations were involved in the preparation of community well-being approach activities in their respective villages in one way or another. However, a number of the respondents had not been involved in the planning of the community well-being approach activities for its enactment. The results also showed that 54% of the household heads were involved in the planning process for the enactment of the community well-being approach in Sirwa location and 82% of them participated in the community unit plans in Ngubereti location. It was also indicated that 74% of the household heads took part in planning of the community unit activities in Koitebes location. However, there were a sizeable number of respondents who were not involved in the planning processes for community well-being approach activities in all the three locations as was demonstrated by 45% of the respondents in Sirwa location, 16% in Ngubereti location and 26% of the respondents in Koitebes location, who revealed that none of them were given the opportunity to participate in planning the community well-being approach activities in. This implies that community participation was above average as those who took part in the planning were more than 50% in each location. The other respondents 45% in Sirwa location were not involved, and 16% and 26% in Ngubereti and Koitebes locations respectively were also not involved, meaning that some of the community

members were lagging behind in the enactiment of community well-being approach which would imply that there would be no ownership of the program be the community members which may lead to poor enactment of the community well-being approach in the long run.

Table 14: Responses of households on planning for community approach activities

Community units	Yes	No	Don't know
Sirwa	54%	45%	1-%
Ngubereti	82%	16%	2%
Koitebes	74%	26%	0%

4.4 Trainings for community well-being volunteers

4.4.1 Basic modules training for communal well-being volunteers

The study results showed that community well-being volunteers were trained on the six basic modules as per the Administration policy which requires that all CHVs should undergo such training after being selected by the community for meeting the recruitment criteria which included a person being able to read and write, being a occupant in the village or community unit. The basic modules include well-being and development, community supremacy and leadership, community backing, and armament, best practices for well-being promotion and disease prevention, basic well-being care and life-saving skills, and management, and use of municipal info and disease investigation.

The results (Table 15) show that 69% of the community well-being volunteers had been trained on the six basic modules listed above, which is always a ten days training course. These basic modules are compulsory for any community well-being volunteer to undergo for him or her to qualify and be considered a community well-being volunteer and being allocated roles and errands. The current Administration policy affirms as a requirement that all community well-being volunteers should assume and complete the 10-day ministry of wellbeing-led basic training prior to the beginning of their roles and responsibilities as CHVs. This result implies that quite a sizeable number of community well-being volunteers

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were trained on the basic modules as per the community well-being volunteer curriculum which contains the six basic modules and the seven technical modules. The 31% of the community well-being volunteers who were not trained on the basic modules were probably those CHVs who were recruited to replace the ones who had dropped out occasioned by lack of stipend or due to natural attrition.

Table 15: Community well-being voluteers training on basic modules

Status	Frequency	Percent
Yes	26	69%
No	12	31%

4.4.2 Community well-being volunteers training on technical modules

The results (Figure 4.7) show that 34% of the CHVs had not been trained on the two technical modules possibly because they were selected to replace community well-being volunteers who had dropped out or were lost through natural attrition. The two technical modules which CHVs were trained were on Family planning (FP) and Maternal Neonatal Child well-being (M.N.C.H), which were three days and five-day trainings respectively. It also implies that these community well-being volunteers who had not been trained and may not be able to offer any technical support to the household they were allocated to serve and as such the households were not receiving the right wellbeing information and advice. In other words, the CHVs who were not trained on the two technical modules may not be able to provide quality well-being care facilities to their households.

The study results showed that there was need to train more community well-being volunteers in the study area to provide quality well-being care services which were also in agreement with world wellbeing organization's view that globally well-being employees are inadequate and that this is one of the emerging problems majorly in developing nations. World wellbeing organization describes this as a worrying situation since it will hamper the achievement of the sustainable development goals number 3 which stresses on the access, affordable and equitable provision of quality well-being care services to the local

community. In response to this shortage of well-being employees, many countries have trained community well-being volunteers so as to bridge this gap and provide essential well-being services to marginalized societies (WHO, 2017).

The other five technical modules which the community well-being volunteers had not been trained on include the following; Water Sanitation and Hygiene (WASH), Communicable diseases, Integrated community case management (I.C.C.M), Non –communicable diseases (NCDs) and nutrition.

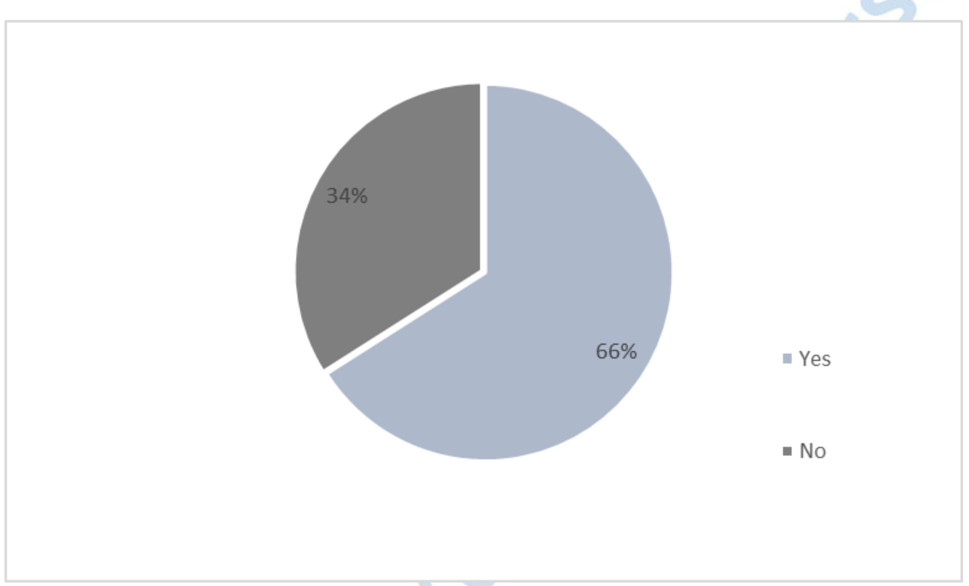

Figure 4.7 CHVs Training on two technical modules

4.4.3 CHV training on other well-being topics

The results (Figure 8) showed that 68% of the community well-being volunteers had not been trained on other well-being topics such as primary eye care (PEC), First Aid, Baby Friendly municipal initiative (BFCI) and behavior modification communiqué (BCC). This implies that the majority of the households did not get well-being updates on these subjects. The few community well-being volunteers (32%) were trained by various partners for example First Aid was supported by world vision, primary eye care and behavior change communication was sponsored by Fred Hollows Foundation (FHF) and Afya Uzazi facilitated the training on baby-friendly community initiative. It was evident that a large

number of community well-being volunteers were not trained on these wellbeing issues probably because the Baringo county Administration had not invested in the establishment and enactiment of community well-being approach and did not allocate adequate money in the well-being budget for community well-being services. Actually, the county Administration depend almost entirely on support from partners, Non-Administrational Organizations (NGOs) and other supporters to fund community well-being approach activities including trainings, and this explains why community well-being volunteers had not been trained adequately and were not given stipend nor provided with any form of motivation, which made it difficult for them to attend trainings and other community unit activities.

This result was in contrast with the results in Ethiopia, which revealed that community well-being volunteers were given money in the form of stipend from household Kitty established by the members of the household arising from contributions they make with the sole motive of motivating their community well-being volunteers., The trained community well-being volunteers have continued to drop out of the program which has become a big problem for the enactiment of community well-being approach program across many nations (Mbugua et al., 2018)

The National administration through the ministry of wellbeing showed good intention in provision of community well-being services. The MOH had announced in the year 2019 that the administration required 11 billion to employ 100000 community well-being volunteers for the next four years, which translates to about 2128 community well-being volunteers per county. The Administration of Kenya also confirmed that it required 20000 wellbeing employees who would supervise the 100000 volunteers. Therefore, much has to be done to put in place such funds to run those plans as Kenya may not improve on her nutrition, maternal and child wellbeing indicators without the services of community volunteers [Rook, 2019].

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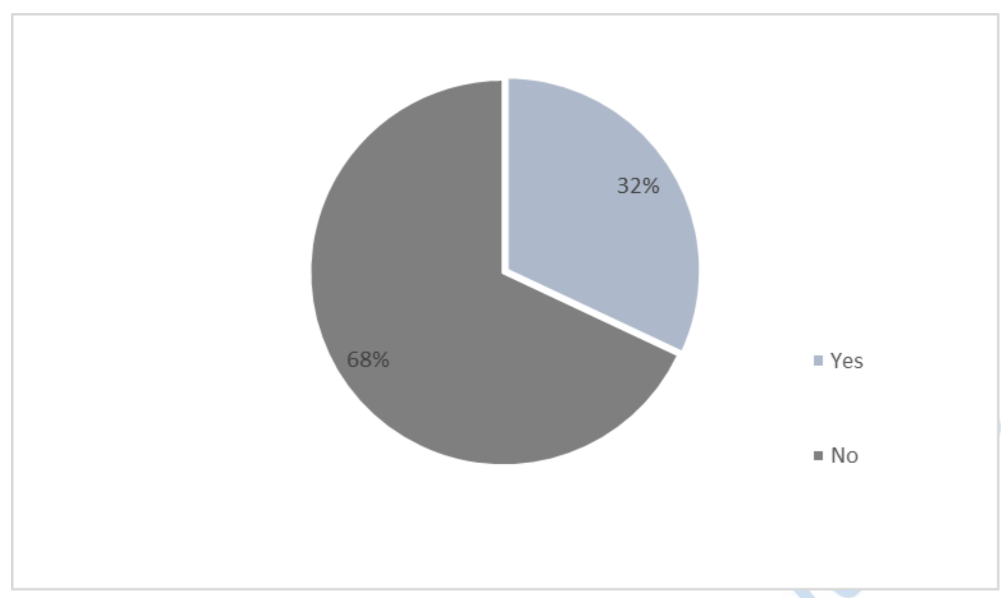

Figure 7: CHVs Training on other wellbeing topics

4.4.4 Roles and responsibilities of community well-being volunteers

The study results (Table 16) show the roles of the community well-being volunteers which included guiding the community on how to improve wellbeing and also prevent diseases by adopting wellbeingy practices. The roles were ranked based on Likert scale (1= no influence, 2= small influence, 3= influence which is medium, 4= influence which is high , 5= influence which is very high). Through Spearman's correlation test all the services had a significant influence on CHS ($P<0.05$). The CHVs provided the roles of treating common ailments and minor injuries and they also gave first aid assisted by the community well-being extension worker. The community well-being volunteers also did referral of patients to the nearest well-being facility for proper care. The CHVs visited households to ascertain their well-being status and engaged households on dialogue and undertake tangible measures for well-being improvement and also promote wellbeing care services at home, especially for people living with terminal illnesses by providing appropriate support, for example, drug adherence for managing wounds, foot-care and many other wellbeing care recommended by the community well-being extension works as a first line treatment for the patients. They also maintained the family registers and kept records of all well-being-related events. Indeed, community well-being volunteers' roles in community well-being care were paramount and these were in agreement with the study of Haven et al. (2018), which defined a community well-being volunteer as either a man or woman who was accorded respect by his or her

fellow municipal members. They also play an important role in improving primary well-being care and as such numerous nations do rely on community well-being program as a vehicle for accessing affordable well-being care and attaining universal well-being coverage (UHC) as the community well-being volunteers were in most cases the first line of contact linkage between the community and the wellbeing care system. Based on all these roles, the CHVs are essential community well-being care providers because they live within the community and understand very well the beliefs and cultures of the local community which may hinder proper enactiment of the community well-being approach (Haven et al., 2018).

Table 16: Roles of Community well-being volunteers

Services	Liker's scale					Parameters			
	1	2	3	4	5	μ (mean)	Σ (SD)	R values	P values
Providing guidance to prevent diseases	6.8	10.2	6.4	5.2	0	5.72	3.7	0.763	0.023**
Treating minor ailments	1.1	12.3	14.7	21.2	31.9	16.2	3.4	0.987	0.011**
Referral of cases	3.2	8.4	17.4	14.4	25.5	13.8	3.4	0.932	0.034**
Maintaining household registers	5.1	3.4	12.17	4.8	6.5	6.4	3.4	0.742	0.046**
Visiting houses for wellbeing education	7.4	24	24	12.4	34.8	20.5	5.4	0.973	0.004**

The Liker's scale show the influence of the CHVs services and the influence in enactiment of Community well-being approach (1= no influence, 2= small influence, 3= influence which is medium, 4= influence which is high , 5= influence which is very high). ** = significant deference at $P<0.05$

4.4.5 Challenges experienced by CHVs in the enactiment of the CHS

The results (Table 17) show the challenges experienced by CHVs in the course of their duties which included inadequate transport at work, poor commitment by the households in enacting issues raised by community well-being volunteers during household visits,the long distance between household at times made the community well-being volunteers feel tired. The challenges were ranked based on Likert scale (1= no influence, 2= small influence, 3= influence which is medium, 4= influence which is high , 5= influence which is very high). Through Spearman's correction test all the challenges experienced by the CHVs had

significant influence on CHS (P<0.05). Furthermore, lack of funds to support the community well-being approach activities, demand for financial and material support by household members, ignorance among some of the household members at times made the community well-being volunteers work difficult. Alcoholism among some of the community members caused misunderstanding on certain facts explained to the households by the community well-being volunteers on some action points deliberated and agreed upon to be undertaken as interventions to address certain problems. Poor road networks resulted on the roads being impassable leading to delay of passing of information to reach the right target group at the right time and the hilly terrain in some villages made walking tiresome especially in Sirwa and Koitebes community units. Lack of adequate training precisely on the technical modules hampered the work of community well-being volunteers making them not able to handle minor illness in the community.

Table 17: Challenges experienced by Community well-being volunteers

Challenges	Liker's scale					Parameters			
	1	2	3	4	5	μ (mean)	Σ (SD)	R values	P values
Lack of awareness	8.8	11.2	7.3	7.5	4	7.7	2.6	0.923	0.012**
Lack of stipends	5.1	14.6	16.7	31.2	33.2	20.1	11.8	0.992	0.001**
Lack of transport service	5.3	9.2	16.1	15.4	18.6	13.0	5.5	0.731	0.022**
Lack of enactiment of issues raised by CHVs	11.51	5.4	10.17	14.2	5.5	9.4	3.9	0.642	0.041**
Lack of funds to support CHS	1.4	12.4	22.8	12.4	34.8	16.8	12.6	0.992	0.012**
Demand for subsidy by household	9.2	7.8	10.1	13.2	17.2	11.5	3.8	0.882	0.004**
Ignorance at the household	4.5	16.2	13	6	23.8	12.7	7.9	0.796	0.0032**
Alcoholism within the community	6.6	11.4	13.2	11.1	21.2	12.7	5.3	0.768	0.015**

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Poor road network	7.5	8.9	21	21.2	19.2	15.6	6.8	0.882	0.032**

The Liker's scale show the influence of the CHVs challenges and the influence in enactiment of Community well-being approach (1= no influence, 2= small influence, 3= influence which is medium, 4= influence which is high , 5= influence which is very high). ** = significant deference at $P<0.05$

The findings of this research are contrary to the results from other countries, for example, in Brazil where the community well-being volunteers were put to be part of the civil servants in the year 1991. They were also earning salary and were recognized as professionals in the wellbeing sector in the year 2002. Community well-being volunteers in Malawi form part of the ministry of wellbeing employees. They were also entitled to monthly payments and other remuneration just like the other wellbeing care employees (Mbugua et al., 2018). The results of this study also revealed that community well-being volunteers experienced numerous challenges as they undertook their roles and responsibilities in the community. The results were in agreement with the study done by Mohajer and Singh (2018) on human resource for wellbeing, which indicated that community well-being volunteers needed to be empowered with social capital in order to meet the expectations of the community to fulfill their non-wellbeing requirements so as to successfully deliver the wellbeing services to the households (Mohajer and Singh, 2018)

4.4.6 Factors enabling sustainability of CHVs activities

The passion to provide wellbeing education to fellow community members to help them adopt good wellbeing practices, driven by personal desire to gain knowledge and skills on maintaining personal hygiene, general, and sanitation of the environment were among some of the reported factors that motivated the CHVs to serve the community. Further to this, the community well-being volunteers also indicated that they had gained facilitation skills and they had become all round facilitators and were even contacted by the community to lead various issues beside their roles. They also stated that being part of the community, they had chosen to volunteer in order to realize a wellbeingy society. Most of the Community well-being volunteers were also motivated by the non-monetary incentives for example T-shirts, bags, and identification barges that were being given to them. They indicated that they were members of a self-help group and had table banking as their income generating activities

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(I.G.A), and so they get encouragement from the community well-being extension employees (CHEWS) and public wellbeing officers (PHOS. Their motivation also came from the passions they developed in sensitizing the community members on matters of child wellbeing and also advising the community to uphold baby friend community initiatives (B.F.C.I), which emphasizes on exclusive breastfeeding of all children aged below six months, good nutrition of pregnant mothers and lactating mothers, complementary feeding, good nutrition of children under one year.

The dialogue and wellbeing action days were conducted quarterly in Ngubereti and Koitebes community units and monthly in Sirwa community unit. The means of transport used by communal well-being extension employees when conducting community unit activities was hired motorbikes in both Koitebes and Ngubereti community units and in Sirwa community unit the community well-being extension employees confirmed that they fuel Administration motorbike using money from their pockets as fuel from Administration office was scanty and not reliable. The development partner supporting community unit activities was Afya Uzazi, which only supported quarterly data review meeting on the last month of every quarter and not monthly. This meant that the first two months in a quarter there was no support provided from neither partners nor county administration.

The research findings are in treaty with that of Mwitary et al. (2018), which highlighted the role of monetary incentives as an incentive and means of retaining the community well-being volunteer within Kibwezi Sub County, Makueni, Kenya. Their study also revealed that community well-being volunteers were mostly motivated by monetary incentives, even if the motivation was so little. Furthermore, the study at Kibwezi also recorded that there was a variation in attrition rate, for instance, a rate of 13% was reported on community well-being volunteers who did not receive any form of money incentives and those who receive money incentive recorded an attrition rate of 4%. Based on this it was noted that giving money or stipend to CHVs played a key role in the continuous delivery of wellbeing services and generally the sustainability of community well-being services (Oyore 2018)

4.5 Characteristics of Community well-being Extension Employees

4.5.1 Gender of community well-being extension employees

The investigator sought to establish the distribution of community well-being extension employees by age, gender, and education level. The findings are presented in Figures 8, 9 and 10 respectively.

The proportion of CHEWs in terms of gender from the sub county wellbeing information showed that female CHEWs were 70% while male CHEWs stood at 30% (DHIS,2018) which when compared with findings of the study showed almost a similar trend as the results (Figure 4.9), showed that (67 %) of the community well-being extension employees were female while only 33 % were male. This implied that the community well-being extension worker workforce was dominated by females. Nevertheless, this was within the two third gender rule as stipulated in the Kenyan constitution (Kenyan constitution 2010). In most cases, community units were run by female CHEWs, this may be due to the nature of work that the community well-being extension employees perform, which are largely dealing with child and maternal wellbeing. This could be because female community well-being extension employees were considered good in multi-tasking as compared to male community well-being extension employees. It also implied that female community well-being extension employees were driven by passion and also loves assisting mothers and children and did not drop out easily as equated to their male equivalents. The disparity may also be due to the fact that female nurses were more than the male nurses in most public wellbeing facilities and they are the wellbeingcare providers considered to be CHEWs and thus this could be one of the reasons why the female CHEWs were more in both scenarios.

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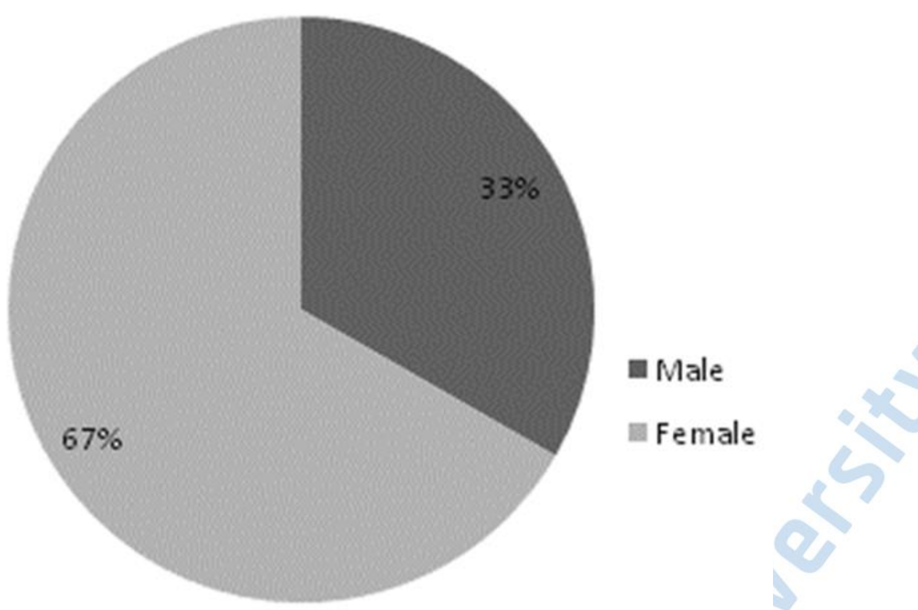

Figure 8: Gender of community well-being extension employees

4.5.2 Age of community well-being extension employees

The wellbeing information in the sub-county showed that CHEWs between the ages of below 25 years were 20% and between 25 years and 45 years were 50% where as those between 46 years and 59 years were30% and there were no CHEWs above 59 years (DHIS,2018) which when compared with the results of this study showed that there were no CHEWs below the age of 25 years as the results on the age of community well-being extension employees (Figure 4.10) indicated that majority (60%) of the community well-being extension employees were between the age of 25 and 45 years and 40 % being between the age of 46 and 59 years. However, no community well-being extension employees were below 25 years or above 59 years. This showed that most of the community well-being extension employees were middle aged, meaning that they had both the experience and energy necessary for the enactment of community well-being approach. The age of 25 to 45 years meant that the community well-being extension employees would be available to serve for a long time before retirement, which would be of great benefit to the enactment of community well-being approach. This would also mean ensure that the sustainability in quality community well-being services would be realized because the community well-being extension employees (CHEWs) would perform their duties competently and with energy. This age category also meant that the community well-being extension employees had stable

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families which meant that they might work in the community unit. Contrary, the 40% who were aged between 46 years and 59 years also had great experience in service delivery and would give the required mentorship to the young community well-being extension employees and community well-being volunteers for the success and sustainability of community well-being service provision.

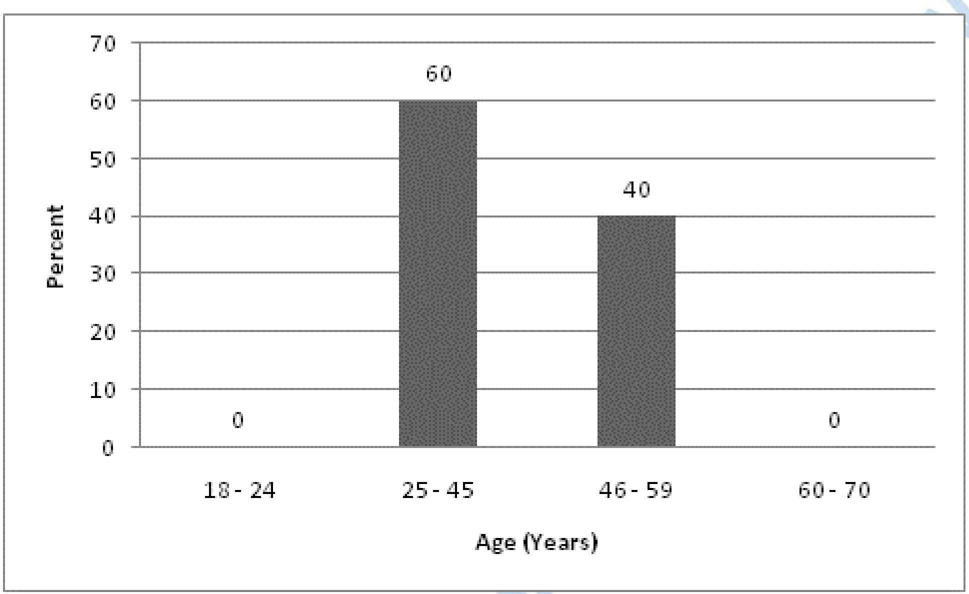

Figure 9: Age of CHEWs

4.5.3 Education level of community well-being extension employees

The findings on education levels for community well-being extension employees (Figure 4.11) indicate that, all the community well-being extension employees (100 %) who participated in the study had attained tertiary education. This was impressive since it implied that they had adequate knowledge and skills concerning the enactment of community well-being approach. The result also showed that all the CHEWs who participated in the study had attended colleges and had gained knowledge and skills necessary for the enactment of the community well-being approach. The CHEWs had also been trained on community unit functions and they could supervise community well-being volunteers to deliver wellbeing care services effectively. It also meant that the commuity well-being extension employees were well trained and they would coordinate community unit activities well and be able to steer the community well-being approach to successful enactment. The CHEWs would also

be able to sensitize the households on the enactiment of the community well-being approach so as to bring about behavior change communication (BCC) in the community and help the households understand and the program. This would also encourage community participation and ownership of the program, as these were some of the key factors that influenced the level of the enactment of community well-being approach. This findings also implied that the availability of well- trained commuity well-being extension employees was a very important factor in the community unit (CU) which would enhance sustainability of community well-being approach owing to the technical advices they rendered to the CUs on various community well-being approach activities. This findings are consistent with the research by Muthamaki, (2019), which indicated that lack of good infrastructure, high cost of wellbeingcare and the rampant shortage of wellbeing employees had reduced the capability of upcoming nations to offer primary well-being care to their citizens (Muthamaki, 2019). However, World Wellbeing Organization (WHO) finding had indicated that Sub-Saharan Africa had 3% of the Worldwide wellbeing workforce. The WHO responded to the shortage of the wellbeing worker force by launching treat, train and retain initiatives in a move aimed at strengthening and expanding the wellbeing workforce in the globe. This initiative involved the formation of more formal cadres of community well-being volunteers, because they were well placed in bridging the gap between households and the wellbeing care system. Indeed, according to WHO, CHVs may as well be used in reinforcing the roles of wellbeing care employees in the delivery of primary wellbeing care in a bid to ensure that wellbeingcare for all is achieved (WHO,2019).

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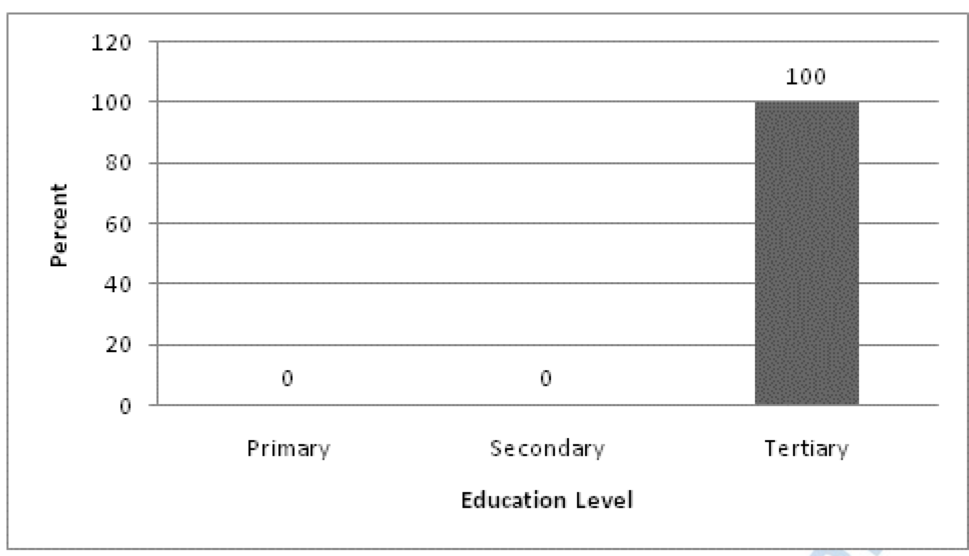

Figure 10: Education level of CHEWs

4.5.4 Challenges faced by CHEWs in the enactment of community well-being approach

Understaffing was the major challenge, each community unit was supposed to have two community well-being extension employees per community unit, but only one community-based CHEW was available to coordinate and supervise the community well-being volunteers in the community. This CHEW gave company to community well-being volunteers when attending community activities especially on community dialogue and wellbeing action days. He or She helped the CHVs to provide wellbeing education, sensitization and advocacy communication social mobilization (ACSM). On the other hand, facility-based community well-being extension worker was always based at the link facility and in most cases, ensured that community unit records were well kept. For example, he or she received referral forms from community well-being volunteers and file them in the hospital and entered the information on the computer as well as updating the chalkboard information. It was worth noting that both CHEWs complemented each other in giving technical advice in the community unit. Some community units, especially in Sirwa and Koitebes locations had only one community well-being extension worker. High work load for the CHEWs who were employees of County administration and had to perform other professional duties and community well-being approach roles was a major challenge. The county administration also had financial constraints, thus not able to support community

well-being activities, for example, they lacked lunch and transport allowance in the first two months in a quarter. There was also lack of adequate wellbeing staff to support the daily and monthly wellbeing action days.

The enactiment of the community well-being approach was being done by the County wellbeing management team in partnership with Afya Uzazi as the main implementing partner through a formal agreement. The two sides signed a working agreement for a certain period of time upon which the contract was either to be renewed or not, depending on the progress and availability of funds. The partner and County team made a joint work plan and set targets which were largely controlled by the partner as it was the main provider of funds, with county administration contributing very little funds for the enactment of community well-being approach activities. The current partner provided support within three Sub-counties including, Mogotio Sub-county out of the six sub districts of Baringo. The findings were not in agreement with the findings of Collins (2014), which indicated that Malawi had a national cadre of community well-being volunteers who were recognized and funded by the Administration, as opposed to the situation within the study area. That meant that the CHVs were provided with stipend and other financial support and had a cadre with better benefits than the Kenyan CHVs who had no cadre nor employment package (Asweto et al., 2016).

4.6 Challenges experienced by the County administration in the enactiment of CHS

The results in (Table 18) show the challenges faced by the county administration in the enactiment of community well-being approach were similar to those contained in the report of DHIS, 2018. The report showed some of the problems experienced in the county included lack of adequate resources from the National administration according to the county director of wellbeing services which were more less the results obtained from this study for there were several challenges that were noted to exist within the County Administration of Baringo as far as the enactment of the community well-being approach was concerned. The challenges were ranked based on Likert scale (1 = No influence, 2= Small influence, 3= influence which is medium, 4= influence which is high , 5 influence which is very high). Through Spearman's correction test all the challenges experienced by the county administration had significant influence on CHS ($P<0.05$). There was lack of sufficient

finances to support the community well-being volunteers, lack of partners to support community well-being approach and poor incentives for documentation, reporting and referral. There was also no provision of stipend for the community well-being volunteers despite their integral role in the enactiment of the program. There was high dropout rate of community well-being volunteers as a consequence of poor motivation. There also occurred inadequate staff, thus both the community-based CHEW and facility-based CHEW who were technical advisers in all the community units had to perform other roles. This subjected them to much workload and hampered with the efficient enactiment of the community well-being approach as they doubled up in performing the professional line duties beside communal well-being approach activities. There was also lack of commitment among some community well-being extension employees and this was a challenge to the committed and hardworking CHEWs.

Table 18: Challenges experienced by the County Administration

Challenges	Liker's scale					Parameters			
	1	2	3	4	5	μ (mean)	Σ (SD)	R values	P values
Inadequate finance to support CHS	8.8	12.4	8.2	20.2	26.4	15.2	7.9	0.962	0.014**
Lack of support from partners	4.4	10.6	8.8	22.2	11.4	11.5	6.6	0.891	0.026**
CHV drop outs	5.8	6.2	13.2	16.2	22.4	12.8	7.0	0.832	0.044**
Inadequate wellbeingcare employees	4.6	8.4	10.1	8.4	11.4	8.9	2.6	0.902	0.042**

The Liker's scale show the influence of the County Administration challenges and the influence in enactiment of Community well-being approach (1= no influence, 2= small influence, 3= influence which is medium, 4= influence which is high , 5= influence which is very high). ** = significant deference at P<0.05

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4.7 Benefits of CHS to communities in Mogotio sub-county, Baringo.

Community well-being Approach introduced in Kenya in 2006 was focused in improving access to primary wellbeingcare services, particularly for underserved rural populations. Since then, the enactiment of the CHS has been ongoing in Kenya, and it has had an important impact on wellbeingcare distribution in the country. One of the key strategies of the CHS is the deployment of community well-being employees (CHWs) who provide wellbeingcare services to households in their communities. The CHWs offer a wide range of services, including wellbeing education, screening for common diseases, and referral services to wellbeing facilities (Ngilangwa, and Mgomella, 2018; Pascal et al., 2021). According to a study published in the Journal of Global Wellbeing, the enactiment of the CHS was linked with a significant decrease in maternal and neonatal death rates in Kenya. The study attributed this to the increased access to wellbeingcare services and improved wellbeing-seeking behavior among the population. Furthermore, the CHS has led to a reduction in wellbeingcare costs for households. The CHWs provide wellbeingcare services at a lower cost compared to formal wellbeingcare facilities, and this has helped to reduce the financial burden of wellbeingcare on households. Despite these successes, the enactiment of the CHS in Kenya has faced challenges. These challenges include inadequate funding, shortages of CHWs, inadequate training, and poor coordination between CHWs and formal wellbeingcare facilities. These challenges have limited the effectiveness of the CHS in some areas. The enactment of the CHS in Kenya has had a significant impact on wellbeingcare delivery, particularly in rural areas. The CHS has aided in the increase of wellbeingcare access services, improve parental and teenager well-being outcomes, and reduce wellbeingcare costs for households. However, addressing the challenges facing the enactiment of the CHS, such as inadequate funding and shortages of CHWs, will be crucial for the continued success of the approach (Asiki et al., 2018).

Motivation has been found to be a precarious factor in the successful enactment of any community-based wellbeingcare approach, including the Community well-being Approach (CHS) in Kenya. Unfortunately, lack of motivation among community well-being employees (CHWs) has been a significant challenge in the enactiment of the CHS in some areas. One of the reasons for the lack of motivation among CHWs is inadequate compensation Mogotio (Wangalwa et al., 2012; Walcott et. Al 2021; Lee et al, 2022). CHWs

in Kenya are usually volunteers or receive a small stipend, which may not be sufficient to support their basic needs. Another issue that backs to the lack of incentives among CHWs is the lack of recognition and appreciation for their work. CHWs often work in difficult and challenging conditions, but they may not receive the recognition and appreciation they deserve from the community and formal wellbeingcare system. This can lead to feelings of demotivation and burnout among CHWs. Inadequate training and supervision can also contribute to the lack of motivation among CHWs. CHWs require continuous training and supervision to perform their roles effectively. However, when training and supervision are inadequate, CHWs may not have the necessary skills and knowledge to provide quality wellbeingcare services. This can lead to an emotional state of defeat and demotivation among CHWs (Ng et al., 2021). Furthermore, lack of resources and support can also contribute to the lack of motivation among CHWs. CHWs require adequate medical supplies, equipment, and logistical support to perform their roles effectively. When these resources are inadequate, CHWs may not be able to provide the necessary wellbeingcare services, leading to feelings of frustration and demotivation. Therefore, the lack of motivation among communal well-being employees is an important challenge in the enactiment of the Community well-being Approach in Kenya. Addressing the factors that contribute to the lack of motivation, such as inadequate compensation, lack of recognition and appreciation, inadequate training and supervision, and lack of resources and support, will be critical for the continued success of the CHS. Providing CHWs with adequate compensation, recognition, training, supervision, and resources will help to improve their motivation and ensure the successful enactiment of the CHS (Mogotio (Wangalwa et al., 2012; Sorato et al., 2021; Lee et al, 2022).

The wellbeing information contained in DHIS,2018 showed there was a decline in wellbeing indicators but the results of this research specify that the well-being indicators were improving for example there was community involvement in sector planning and this provided the efficiency in communication of wellbeing policy information to the community. This resulted to improved skilled birth attendance (S.B.A) from the 35% recorded in 2013 to 45% in 2018 (KDHS, 2018). The sub county also experienced a rise in the number of under five year children being reached for immunization as well as an improved patient referral system. The sub-county also experienced an increased awareness

among community members on good hygiene practices and sanitation matters. This ensured that the household visitation by community well-being volunteers yielded improved wellbeing and behavior in the community. Additionally, there was an enhancement in the number of pregnant women seeking Ante Natal Clinic. The trainings provided to community well-being volunteers with knowledge on baby friendly community initiative (BFCI), and this resulted to improved nutrition in the community.

4.8 Role of County Administration in the Provision of Resources for the Enactment of CHS

The information on the role of county administration in the provision of resources for the enactiment of community well-being approach was obtained from the key informants who included the County Executive Committee (CEC), District director of wellbeing services, county community well-being approach focal person, county public well-being officer (CPHO) and community well-being extension employees. The information was gathered using the interview schedules that yielded qualitative data. The study findings showed that the county wellbeing management team had been trained on the enactiment of community well-being approach. The county administration had also sourced for partners to support community well-being activities to help solve wellbeing problems at the community level. There was commitment of the county administration in the enactment of community well-being approach program. The county Administration also confirmed that they were engaging other stakeholders and well-wishers to solicit money for funding the enactment of community well-being approach activities in the county. This was in line with the fact that many African and South East Asia countries were strategically putting policies and plans in place to implement community well-being volunteers program (Greenspan et al., 2013).

The research results also showed that community well-being approach coverage in the county stood at 37.3%, which was contrary to what was displayed by the Ugandan administration which valued the wellbeingcare services provided to the community members for the efforts of trying to attain the universal wellbeing coverage (UHC) courtesy of community well-being volunteers' efforts (Kuule et al, 2017).

4.8.1 Facilitation

The DHIS, 2018 report indicates that community well-being approach activities received less support which was supported with the findings of this research which indicated that there was little support for the execution of community well-being approach activities as the county wellbeing management team indicated that the county administration plays a big duty in the provision of drugs and medical equipment to be used during community well-being action days and community well-being outreaches. They also confirmed to be supporting activities like free medical camps, which motivated the members of the community to ensure that they attended and participated in the days' activities. This also helped during the trainings by ensuring that the trainers showed practical demonstrations as opposed to theories. Such form of trainings made it easy for the members of the community to follow through and understand, hence encouraged them to practice what they learned. The facilitation also established the construction of structures, for instance, latrines for the community that boosted their sanitation and preventing disease outbreaks. This was achieved through the county administration mobilizing resources from other partners.

Since the wellbeing sector is a devolved function of governance, it was the decree of the county administration to provide the wellbeingcare work force. The county administration provided the wellbeingcare employees which included the Community well-being Extension Employees (CHEWs) mandated to implement the community well-being approach. The county administration recruited, trained, deployed and facilitated the wellbeing work force, therefore enabling enactiment of community well-being approach. The county administration was supposed to ensure adequate wellbeingcare work force in terms of numbers and areas of specialization that could serve the community well and prevent outbreaks of communicable diseases in the community.

County administration facilitated the operations of Community well-being Extension Employees in the enactment of community well-being approach. Additionally, the county administration provided the reporting materials for the Community well-being Extension Employees and Community well-being Volunteers and also provided resources to support community well-being approach activities, for example the community dialogue days. They also provided the means of transport, mainly motorcycles to facilitate their operations

although at times they failed to provide sufficient fuel. The Community well-being Extension Employees are also given office space to plan for their activities.

4.8.2 Policy Review

The county administration has good wellbeing policies for example the Kenya community well-being Policy of 2020-2030 for which more information is found in the Division of community well-being and also the Kenya Well-being policy 2014-2030 and as such through the interview with the county wellbeing management team, it was noted that the county administration provided the policy guidelines for the enactiment of community well-being approach. It was also noted that the County Executive Committee (CEC) achieved this through preparing bills that supported the enactment of community well-being approach. The Bills were tabled in the county assembly for debate, review, amendments and adoption. After the bills were passed in the assemblies, they were given to the county executive for assenting into law. The bills were then gazette after which they were to be implemented by respective officers in the county. Based on this role of the County Administration in policy formulation and enactiment, it is therefore important for the county leadership to give priorities to the wellbeing of its citizens by formulating policies and guidelines that safe guard the wellbeing wellbeing within the county.

4.8.3 Supervision

The Kenya essential package of wellbeing (KEPH) and the second National Wellbeing Sector Strategic Plan, 2014-2018 (NHSSP 11) stipulates in its guidelines that community well-being activities should be supervised by county wellbeing management teams which were in treaty with the results of the study obtained after interviewing the County wellbeing management team (CHMT) which revealed that they also provided supportive supervision to both community well-being extension employees and community well-being volunteers. The county administration was also found to provide mentorship to community well-being volunteers for better delivery of wellbeing services at the community level that is in line with community well-being approach enactiment. The county public wellbeing officers must ensure that the general wellbeing standards are adhered to in all sectors that deal with the society for example in wellbeing facilities, schools and hotels among other public amenities

which would safeguard the wellbeing of the public and encourage the household members to adhere to good wellbeing practices for better wellbeing outcomes.

4.8.4 Wellbeing Reporting

The wellbeing information contained in the DHIS, 2018 in the ministry of wellbeing reporting tool (MOH, 515) which indicated that the average reporting rate for CHVs stood at 72% which when compared with the results of this research discovered that the DHIS,2018 reporting rate of the CHVs was higher than the rate obtained from the study findings as the Community well-being Extension Employees indicated that majority of Community well-being Volunteers reporting rate was found to be 66.5 %. However, the Community well-being Extension Employees stated that the reporting rates were indeed on a decline trend. The wellbeing reports were found to comprise of wellbeing indicators, disease surveillance as well as the feedback from members of the community.

4.8.5 Community Outreach

The DHIS,2018 report showed that the community dialogue days were done on quarterly basis and wellbeing action days were held monthly which was in line and as regulated in the CHV training manual and CHV curriculum revised 2016 which was contrary to the results from the study which revealed that both were held quarterly which implies that the wellbeing action days were not done monthly as expected as the research also aimed to inaugurate how often the Community well-being Extension Employees conducted dialogue days and Wellbeing action days to the community. The community outreach fora were found to provide a platform where members of community were trained on how to construct toilets so as to improve their sanitation. In the outreach, the members of community were taken through the preventive mechanisms for diseases like TB, diarrhea among other communicable diseases. The child welfare for both pregnant women as well as lactating mothers was also given priority in the community outreach. This usually targets to reduce child mortality and morbidity rates. The county administration provided motorcycles to Community well-being Extension Employees to facilitate them access the members of community. Mogotio Sub County being a vast region in terms of size, and with a scattered population which was not densely populated, the motorcycles enable the Community well-being Extension Employees to cover large areas efficiently.

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4.8.6 Partnerships

The sub-county wellbeing information report of DHIS, 2018 indicated that there were several partners collaborating with the county administration for the provision of wellbeing care services at the facility and at the community level which were similar to the results of this study obtained after interviewing community well-being extension employees for they pointed out that there were several partners who worked hand in hand with the county administration. They stated that Afya Uzazi was one of the organizations that supported child and mother welfare in Mogotio Sub County. Another partner that was cited was the World Vision that was said to support sanitation by building toilets as well as supporting the nutrition through programs aimed at reducing malnutrition among youngsters under 5 years. However, the study findings showed that county administration and partners did not motivate the CHVs adequately. This was contrary to the situation in Tanzania where the administration collaborated with partners to motivate CHVs by providing them with stipend, provision of employment opportunities, commodities and other non-monetary incentives (Urassa et-al, 2013).

The County Administration of Baringo recognized that there was need to train CHVs to adequately provide wellbeingcare services to the community. This was consistent with the world wellbeing association plan of promoting the use of communal well-being volunteers in enhancing access of wellbeingcare services to millions of people in the continent of Africa (WHO, 2013).

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CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.0 Introduction

This section consists of the research findings summary, study conclusion, and recommendation of the study.

5.1 Research Findings Summary

This section contains a research findings summary which has been provided objective-wise.

5.1.1 Training capacity provided to CHVs for the enactment of CHS

With the 52.2% of community well-being volunteers having attained secondary school education level of qualification and 26.1% having attained tertiary education level of qualification while 21.7% having attained primary school education level of qualification, was an indication that the community well-being volunteers would easily understand the concepts of community well-being approach during the trainings. This explains why all of them managed to finish the basic module trainings and further implied they acquired knowledge in satisfactorily implementing the community well-being approach. However, this also needed the necessary resources to be adequately availed by the county administration and other stakeholders in the wellbeing set up. The study also showed that 69% of the community well-being volunteers had been trained on the six basic modules as a prerequisite qualification for a CHV before being allowed to work or being assigned any role for the enactiment of community well-being approach. On the other hand, 31% of them had not been fully trained on the basic modules but were given on job training (OJT) by the community well-being extension worker (CHEW) who is the community unit technical advisor. The untrained community well-being volunteers also received mentorship from the fully trained CHVs because the county administration in most cases did not provide CHVs' training but depended on partners to sponsor most of the community wellbeing policy trainings.

The study also showed that the CHVs were not adequately trained on the technical modules, some of them (34%) had not been trained on the two technical modules (reproductive wellbeing planning (FP) and Maternal and neonatal teenager wellbeing) out of the seven

technical modules. This meant that only 66% of them had been trained, indicating the existence of a big gap in terms of the technical modules training across the three community units. Therefore, the community well-being volunteers were not adequately trained on both the basic and the technical modules. It was evident that 68% of the communal well-being volunteers were not also skilled on other wellbeing topics which included first Aid, behavior change communication (BCC), primary eye care (PEC), baby friendly community initiative (BFCI) and community led total sanitation (CLTS). This showed that that only 32% of the CHVs were privileged to be trained on these wellbeing topics and therefore this would mean that the community units did not have the necessary expertise for the enactiment of a community well-being approach. This may be considered as one of the factors that influenced the level of enactiment of the program because the training capacity of community well-being volunteers was key for the effective enactment of community well-being approach at the community level. To strengthen the execution of the community well-being approach, the CHVs were given capacity building and supportive supervision by CHEWs who are frontline wellbeingcare employees receiving salary monthly

5.1.2 Role of County Administration in the Provision of Resources for the enactment of CHS

The study found out that the county administration provided policy direction and guidelines which enabled the department of wellbeing services to strategies and plan for the enactiment of CHS. It sourced for partners and other well-wishers to help fund the foundation of new community well-being units and revitalize the prevailing ones which had also been established earlier by partners. The community unit coverage for the county was found to be at 37.3%, and there were a total of 56 community units and the county needs 150 community units in order to cover the whole county as was stated by the district director of wellbeing services and county community well-being approach focal person (CCHSFP). The community unit coverage for Mogotio sub-county was found to be at 37.5% which translated to 9 community units out of 24 community units required to cover the whole of Mogotio sub-county. This was slightly higher than that of the county. The research revealed that the county administration also prepared wellbeing bills which were tabled in the county assembly through the county executive committee (CEC). These bills covered all the departments of wellbeing including the unit of CHS. Both the national administration and

the county administration have good well-being policies, this emerged from the research findings, however, the enactment of the same was minimal or lacking. It was also realized that the county administration played a key role in provision of human resource and material resources and sourced for partners who would provide funds for enactment of CHS in sub-counties including Mogotio. It also provided drugs and equipment through Kenya Medical Supplies Agency (KEMSA) which were utilized during community-integrated outreaches and wellbeing action days especially in hard to reach areas where there was no provision of well being care either by both private and public well-being amenities. The county administration also facilitated supportive supervision to all community well-being extension employees and community well-being volunteers in the enactment of community well-being approach. Both county well-being management team (CHMT) and sub-county well-being management team (SCHMT) did the supervision in a quarterly basis in collaboration with partners.

5.1.3 Awareness of the Community on the Enactment of Communal Well-being Approach

The study showed that a substantial proportion (46%) of household heads had only attained primary level of education, 36% of them had secondary level of education qualification, while 18% had acquired tertiary education level qualification. This implied that education level was low and therefore creating awareness might not be effective because most of them found it difficult to understand some of the wellbeing concepts regarding the enactment of community well-being approach. Thus, it would require the community well-being volunteers and other key players to put a lot of effort in order to be able to pass wellbeing messages and this could explain the reason why there was low dissemination of information on CHS in the community. Through the study, it was found that the economic status of the community was equally low and this might have been the reason why some community members or households persistently asked for subsidies from the community well-being volunteers whenever they visited their households. This made some of the community members to pay little attention to the wellbeing messages given by the community well-being volunteers through wellbeing education as they insisted on subsidy provision, to the extent that it overrides the noble course of CHVs visitation. The household members also showed a lot of ignorance and lack of commitment to execute even the very basic

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interventions put in place by the community well-being volunteers and community well-being extension employees to tackle certain wellbeing problems. The fact that majority of household heads 91%, 90% and 86% in Sirwa location, Ngubereti location and Koitebes location respectively confirmed that they knew and well understood what CHS was all about was an indication that the community were aware of the enactment of CHS program in their respective villages. The proportion of community well-being volunteers' visitation to households stood at 89%, 93% and 83% in Sirwa, Ngubereti and Koitebes locations respectively. This implied that the level of awareness on the enactiment of CHS was good as most of the households had interacted well with their respective CHVs, especially during wellbeing education sessions and cancelling. This was found to be impressive as it ensured continuity of creating awareness on execution of the program at the community level. Community involvement on both dialogue and wellbeing action days was found to be at 28%, 72% and 60% in Sirwa Ngubereti and Koitebes locations respectively which suggested that the level of awareness of the program was relatively low in Sirwa location compared to the other two locations of Ngubereti and Koitebes.

The community well-being extension employees indicated that the county administration had a big role in the provision of drugs and medical equipment to be used during the community well-being action days and wellbeing outreaches. The support activities like free medical camps acted as a motivation to the members of the community to ensure that they attended and participated in the days' activities. This also helped during the trainings by ensuring that the trainers showed the practical demonstrations as opposed to theories.

The research also revealed that the county administration provided the well being care employees which included the CHEWs mandated to implement the CHS. The county administration provided the reporting materials for the CHEWs and CHVs. The county wellbeing management team through the face to face interview informed the researcher that the county administration provided the policy guidelines for the enactment of CHS. From the study, it was revealed that the county wellbeing management team provided supportive supervision to community well-being extension employees and community well-being volunteers. The county administration was also found to provide mentorship to community well-being volunteers for better provision of well-being services at the community level that

was in line with community well-being approach enactment. The community well-being Extension Employees indicated that majority of community well-being Wellbeing Volunteers reporting rate could be estimated to be 66.5 %. The study indicated that the dialogue and wellbeing action days were mostly done on a quarterly basis. The community outreach forums were found to provide a platform where members of the community were trained on how to construct toilets so as to improve their sanitation. Through the face-to-face interview, the CHEWs pointed out that several partners worked hand in hand with the county administration. Majority of the household heads (91 %) stated that they had heard about community well-being approach and majority of the them (92%) indicated that they knew their CHVs and another proportion (57 %) indicated that they were given room to participate in planning for CHS activities.

Majority of the household heads (92 %) who participated in the study stated that they had been visited by, with only 8 % stating otherwise. Majority of the household heads (87 %) who participated in the study considered the community well-being approach to be beneficial to the community, and only 13 % having contrary opinion. The community members participated in the selection of community well-being committees (CHCs) at the chief baraza and this implied that they were much aware of the enactment of CHS. They also took part in the identification of CHVs. Members of the households cooperated with community well-being volunteers in giving information and answering the questions they presented to them. The study also revealed that the community members participated in discussion of wellbeing indicators as presented in the chalkboard by community well-being extension employees. The chalkboard was like a mirror of how the community looks like in terms of wellbeing status as it showed the trends of wellbeing indicators which would then attract reactions and deliberations culminating into drawing action points for carrying out agreed interventions to tackle certain problems in the community. The study also showed that households could well understand the benefits of community well-being approach enactment in their community which implied that they were aware of the program activities and they valued it as they believed that it had changed their lives. The fact that the households took part in wellbeing action days meant that they fully supported these activities, CHCs helped CHVs when performing their roles for example when carrying out social mobilization and household registration, which was a biannual activity done by enrolling all households in the

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community to take stock of the status of wellbeing indicators which would be used for six months before carrying out another fresh registration of the households.

5.1.4 Challenges faced by Community Well-being Volunteers in the Enactment of CHS

The study found out that the community well-being volunteers were not adequately trained on both the basic and the technical modules and as such they were not able to execute their mandate satisfactorily. Majority of the CHVs were trained on the basic modules but due to lack of stipend, some of them had to drop out and those who replaced them were never subjected to the same training, but were only given on job training, this showed that they lacked the necessary knowledge and skills to successfully implement the community well-being approach. They were also not adequately trained on the technical modules, making some of them not to provide adequate wellbeingcare services to their communities. Some of the households were economically poor and kept asking for subsidies from the CHVs, putting the CHVs on difficult scenario during their routine household visits. Lack of transport when visiting households and during reporting was one of the outstanding challenge that the CHVs experienced and this could have been the reason why a big proportion of households 11%, 7% and 17% in Sirwa, Ngubereti and Koitebes locations respectively, were not visited by the community well-being volunteers. Lack of commitment to implement interventions advised by the CHVs to curb or control certain wellbeing problems was demonstrated by many households not participating in the dialogue and wellbeing action days. Indeed, it was evident that 72%, 26% and 38% of them did not take part in the two community functions in Sirwa, Ngubereti and Koitebes locations respectively. Ignorance also featured as one of the challenges and households did not participate in the planning process for the enactment of community well-being approach. Some households had harmful cultural practices which they have continued to value. A case in point was the claim that an old person should not use one toilet with a young person, this believe may slow down the wellbeing outcomes expected in the long run even after carrying out certain interventions aimed at solving wellbeing problems in the community.

The community well-being volunteers were poor in reporting. This was attributed to by lack of adequate reporting tools as well as the relevant skills for reporting. The reports were also given in different formats some of which were not easy to implement. It was also challenging

for them to go door to door, inspecting and educating members of community. There was poor motivation of community well-being volunteers and this was one of the major challenges to their participation in the enactment of community well-being Approach. The community well-being volunteers were found to withdraw from their participation due to lack of stipend. The county administration was not able to adequately outsource for resources from partners and collaborators so as to support enactiment of the Community well-being Approach.

The respondents were fairly representative as both genders were within the gender rules of one gender not being more than two third in numbers, as stipulated in the Kenyan constitution of 2010. The results revealed that many of the household heads were within the age bracket of 25-45 years across all the three locations. This implied that many of the participants were energetic and strong enough to implement the community well-being activities robustly and efficiently. This age category was also good for sustainability of community well-being approach activities.

The level of education of house hold heads showed that a significant number of them (46%) had only attained primary education level qualification. This meant that their level of understanding of the wellbeing issues would be low and therefore dissemination of wellbeing information would as well be poor which would affect the enactment of the community well-being approach in the long run. The results also showed that 36% of respondents had secondary education level of qualification, this implied that their chances of securing any form of employment was minimal and as such the economic status of the community was low, a situation that influenced the level of enactment of community well-being approach. On the other hand, the respondents who had tertiary education level of qualification (18%) implied that the community lacked sufficient professionals such as community well-being extension employees who would steer economic growth and bolster development in the wellbeing sector.

The occupation of household members who took part in the study show that only 12% of the respondents in Sirwa, 21% in Ngubereti and 26% in Koitebes location were employed, which meant that majority of the participants were either engaged in casual work, business or lacked employment. Therefore, the community members were not able to motivate the

community well-being volunteers either in terms of monetary nor non-monetary incentives because a few of them only had formal employment. Majority of respondents, 91%, 90% and 86% in Sirwa Ngubereti and Koitebes respectively knew about the existence of the community well-being approach in their locations. Therefore, the community approach program activities were familiar to the majority of the community members, however, the enactiment progress was poor. It was also evident that a good number of household heads were familiar with their community well-being volunteers. This was further confirmed by the fact that many of the participants were able to recall the names of their community well-being volunteers. This implied that the household heads could relate well with their CHVS and this could also further mean that the roles of the community well-being volunteers were made easier. Community well-being volunteers were also noted to be active as was demonstrated by the fact that majority (82%) of the households had been visited by communal well-being volunteers. This further meant that CHVs could deal with wellbeing issues promptly as they were always in touch with households and could detect wellbeing problems early enough for any intervention to be undertaken.

5.2 Conclusion

1. CHVs were poorly trained on both the basic and technical modules.
2. Community well-being approach is being implemented by the county administration though operationalization is low. The County administration has not adequately taken up the roles that would ensure efficient wellbeing service delivery through CHS within Mogotio Sub-County
3. Education level was low and also involvement in wellbeing action days and other CHS activities were equaly low resulting to poor planning for CHS programs.
4. Both the CHVs and the County Administration faced numerous challenges that interfered with effective enactment of CHS.

5.3 Recommendations

- There is need to provide adequate training to CHVs on the basic modules and technical modules.

- The county administration needs to allocate adequate resources for effective enactment of the CHS program.
- There is need for the county administration to incorporate enactment of CHS in its county integrated development plan
- There is need to facilitate public participation on the enactiment of CHS at the community level to boost awareness of the program.
- There is need to support the poorly remunerated CHVs by providing stipend and other non-monetary incentive.
- There is need for inter-sectoral involvement on the enactiment of CHS to attract more resources.

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APPENDIXES

APPENDIX I: CONSENT FORM

I am BARTENA KIMOSOP SAMUEL REG. NO. MHSM/2018/22271 a student of Mount Kenya University, I am required to conduct a research proposal as part of the requirement to qualify for the award of Master's Degree in Wellbeing Systems Management. I will collect data on assessment of factors influencing the level of enactiment of community well-being approach in Mogotio Sub County, Baringo, Kenya. My respondents will be adults of 18 years to 60 years and above who can still give relevant information necessary for the research study. I am requesting you to participate in answering questions in the questionnaire precisely. The information you will give will be treated with confidentiality it deserves. You are requested to kindly respond by ticking the answer of your choice or fill the provided space accordingly.

Your participation in this research project is entirely voluntary. You may refuse or leave blank question you don't wish to respond. I will leave a participant who decline to answer the questionnaire because it is a voluntary exercise. There are no known risks to participation. All data will be kept under lock and key and reporting will be done collectively. Nobody else will know your answer individually on the questionnaire apart from the researcher. There are no direct benefits to you for participating in this research. However, you may find it interesting to talk about the issues addressed in the research and it may be beneficial to the field and to future clients or individuals who have experienced similar concerns

In the event that you accept to participate in this research, answer the questions as best as you can. It should take approximately Ten (10) minutes to complete.

Respondent's Signature……………………… Date ………………………

If you have any questions about this project, feel free to contact the;

INVESTIGATOR: Bartena Kimosop Samuel, 0720 407 781, sbkimosop@gmail.com.

SUPERVISOR: Dr. M. O. Esilaba, Egerton University, 0735427404 mosesotiali@gmail.com

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APPENDIX II: QUESTIONAIRE FOR COMMUNITY WELL-BEING VOLUNTEERS

DATE…

Ward………………………………………...Location………………………………………

Sub-location…………………………………….Community unit……………………….

You are required to put a tick or fill the space provided where applicable for each question.

BIO DATA

Gender (a) Male [ ] (b) Female [ ]

Age (a) 18 – 24 years [ ] (b) 25 – 45[ ] (c) 46 – 59[ ] (d) 60 - 70 years [ ]

Education level (a) Primary [ ] (b) Secondary [ ] (c) Tertiary [ ]

Occupation (a) Employed [ ] (b) Business person [ ] (c) Not employed [ ] (d) Casual [ ]

1. Have you been trained as community well-being volunteer worker? (a) YES [ ] (b) NO[ ]

   If yes, what training did you received (a) Basic module [ ] (b) Technical modules [ ]

2. Have you been trained on any technical module? (a) YES [ ] (b) NO[ ]

   If yes specify………………………………………………………

3. Have you been trained on any other subject apart from the basic and technical modules? (a) YES [ ] (b) NO [ ]

If Yes specify……………………………………………………………………………

4. How long have you been working as a CHV? Specify the duration …………….

5. What motivates you to continue working as a CHV? ………………………………

6. What mode of transport do you mostly use when visiting households?

a). On foot [ ], Bicycle [ ] Motorbike [ ] Vehicle [ ]

7. Do you have the tools necessary for Community well-being Information System (CHIS)? (a) YES [ ] (b) NO [ ]

8. What challenges do you face in implementing Communal well-being approach …………………………………………………………………………………………..

9. Among the challenges, which one do you consider the most significant?

………………………………………………………………………………………………..

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APPENDIX III: QUESTIONAIRES FOR COMMUNITY WELL-BEING EXTENSION EMPLOYEES

DATE: ………………………….

Ward……………………………………...Location………………………………………
.

Sub-location…………………………………….Community unit……………………….

You are required to put a tick or fill the space provided where applicable for each question.

BIO DATA

Gender (a) Male [ ] (b) Female [ ]

Age (a) 18 – 24 years [ ] (b) 25 – 45[ ] (c) 46 – 59[ ] (d) 60 - 70 years [ ]

Education level (a) Primary [ ] (b) Secondary [ ] (c) Tertiary [ ]

Occupation (a) Employed [ ] (b) Business person [ ] (c) Not employed [ ] (d) Casual [ ]

1. What is the reporting rate range for community well-being volunteers? (a) 70%-79% [ ] (b) 60%-69%[ ] (c) 80%-90% [ ] (d) 50%-59%[ ] (e) 100% and above [ ]
2. How often do you conduct dialogue days and Wellbeing action days?
   (a) Monthly [ ] (b) Quarterly [ ] (c) None [ ] (d) Annually [ ]
3. What means of transport do you have for coordinating community unit activities
   (a) Bicycle [ ] (b) motorbike [ ] (c) none [ ] (d) vehicle [ ]
4. Who supports community unity monthly feedback meeting?
   (a) County administration of Baringo [ ] (b) Partners [ ] (c) No monthly support [ ]
5. Do you have a partner supporting community unit activities (a) No [ ] (b) Yes[ ]
   If yes what activities do they support?

   (a) Monthly feedback meeting [ ] (b) Quarterly data review [ ]

   (c)Dialogue and Wellbeing action days [ ]

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APPENDIX IV: QUESTIONAIRE FOR HOUSEHOLD HEADS

DATE:……………………….

Ward……………………………………...Location…………………………………………..

Sub-location……………………………………..Community unit……………………….

You are required to put a tick or fill the space provided where applicable for each question.

BIO DATA

Gender (a) Male [ ] (b) Female [ ]

Age (a) 18 – 24 years [ ] (b) 25 – 45[ ] (c) 46 – 59[ ] (d) 60 - 70 years [ ]

Education level (a) Primary [ ] (b) Secondary [ ] (c) Tertiary [ ]

Occupation (a) Employed [ ] (b) Business person [ ] (c) Not employed [ ] (d) Casual [ ]

1. Have you heard of communal well-being approach?
   Yes [ ] (b) No [ ] (c) Don't know [ ]
2. Do you know your community well-being volunteer (a) Yes[ ] (b) No[ ] (c) Don't know[ ]
3. Do you participate in dialogue and Wellbeing action day? (a) Yes[ ] (b) No[ ]
   (c) Don't know [ ]

4. Have you been visited by a Community well-being Volunteer?

(a) Yes [ ] (b) No [ ] (c) Don't know [ ]

5. Are you involved in planning for Community well-being Approach activities?

(a) Yes [ ] (b) No [ ] (c) Don't know [ ]

If yes, how? …………………………………………………

Mount Kenya University

APPENDIX V: INTERVIEW SCHEDULE FOR COUNTY WELLBEING OFFICERS

DATE:……………………….

1. Are you implementing Community well-being Approach?

(a) Yes [ ] (b) No [ ]

If yes how do you implement?..

(a) Partner support [ ] (b) County administration support [ ]

(c) National administration support [ ]

2. What is the coverage of community well-being units' establishment in Baringo County and in Mogotio sub-county the study area?

Specify the coverage in percentages…………………………………………………………

3. What plans do you have in place in up scaling the establishment of community well-being approach in Mogotio Sub-County?... 4. What plans do you have for community well-being approach sustainability in case partners exit the county?...

5. Do you provide stipend to Community well-being Volunteer?

(a) Yes [ ] (b) No [ ]

If No what plans do you have for the same?...

Mount Kenya University

APPENDIX VI: INTRODUCTION LETTER TO NACOSTI

SCHOOL OF POSTGRADUATE STUDIES

MHSM/2018/22271

14th November. 2019

The Director, Research Coordination Division
National Commission for Science, Technology & Innovation
Utalii House, 8th & 9th Floor
P.O Box 30623- 00100
NAIROBI

Dear Sir/Madam,

RE: BARTENA KIMOSOP SAMEUL– REGISTRATION NO. MHSM/2018/22271

The purpose of this letter is to introduce the above named student who is pursuing **Master of Science in Health System Management** in the **Department of Health Management and Informatics** in the **School of Public Health.**

The title of his research is *"Assessment of Factors Influencing the Level of Implementation of Community Health Strategy in Mogotio Sub County, Baringo, Kenya."*

He has been cleared by the University's Ethics Review Committee (Certificate attached) and now has to proceed to the field to collect data for his research between **November 2019 and January, 2020.**

Any assistance accorded to him will be highly appreciated.

Thank you.

Mount Kenya University
Dean, School of Postgraduate Studies
P.O. Box 342 - 01000,
THIKA

Dr. Samuel M. Karenga, Ph.D
Dean, School of Postgraduate Studies
Enc.

APPENDIX VII: ERC LETTER FROM MKU

REF: **MKU/ERC/1369** Date: 16 September 2019

TO: **BARTENA KIMOSOP SAMUEL** REG: **MHSM/2018/22271**

Dear Sir/Madam,

RE: ASSESSMENT OF FACTORS INFLUENCING THE LEVEL OF IMPLEMENTATION OF COMMUNITY HEALTH STRATEGY IN MOGOTIO SUB COUNTY, BARINGO, KENYA

This is to inform you that **Mount Kenya University** has reviewed and approved your above research proposal. Your application approval number is **773.** The approval period is **16/09/2019 – 15/09/2020.**

This approval is subject to compliance with the following requirements;

i. Only approved documents including informed consents, study instruments, MTA will be used
ii. All changes including amendments, deviations and violations are submitted for review and approval by **Mount Kenya University**
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **Mount Kenya University** within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to **Mount Kenya University** within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal
vii. Submission of an executive summary report within 90 days upon completion of the study to **Mount Kenya University**

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

The Chairman
Mount Kenya University
Ethics Review Committee
P. O. Box 342 - 0100, Thika

Prof. Francis W. Muregi
Chairman, Mount Kenya University IERC

Main Campus, General Kago Road, P.O. Box 342-01000 Thika. Tel: +254 67 2820 000,
Cell: +254 720 790 796, 0709 153 000
Email:info@mku.ac.ke, Web: www.mku.ac.ke
Chartered and ISO 9001 : 2015 Certified Institution.
Unlocking Infinite Possibilities

APPENDIX VIII: AUTHORITY LETTER FROM BARINGO COUNTY WELLBEING SERVICES

REPUBLIC OF KENYA
BARINGO COUNTY GOVERNMENT

Tel: 0724264384
Email:
comedicalservices@baringo.go.ke
toromogk@yahoo.com

Chief Officer, Medical Services
P.O. BOX 21-30400,
KABARNET

DEPARTMENT OF HEALTH SERVICES

REF: BCG/HS/ HRM/04/VOL.

DATE: 18th October, 2019

To whom it may concern:

Dear Sir/Madam,

RE: AUTHORITY LETTER FOR DATA COLLECTION FOR BARTENA KIMOSOP SAMUEL

The Health department of Baringo County has given permission to the above Mount Kenya University student to carry out his research study in three community units of Ngubereti, Koitebes and Sirwa Mogotio ward in Mogotio Sub County. His research title is **Assessment of factors influencing the level of implementation of community health strategy**.

Please accord him the necessary assistance.

Thank you.

COUNTY DIRECTOR FOR HEALTH MEDICAL SERVICE
18 OCT 2019
BARINGO COUNTY GOVERNMENT
P.O. BOX 53-30400, KABARNET

Dr. Abakalwa MSG
County Director , Medical Service
Baringo County

APPENDIX IX: AUTHORITY LETTER FROM MINISTRY OF EDUCATION MOGOTIO SUB- COUNTY

MINISTRY OF EDUCATION

Email:deomogotio@gmail.com

Sub County Education Office
Mogotio Sub County
P.O. Box 91,
MOGOTIO.

Date: 18th October, 2019

REF:MGT/ED/GEN/52/VOL.I/170

TO WHOM IT MAY CONCERN

RE: AUTHORITY LETTER FOR DATA COLLECTION FOR BARTENA KIMOSOP SAMUEL

The bearer of this letter is a student at Mt. Kenya University who is undertaking a research study in three community units of Ngubereti, Koitebes and Sirwa Mogotio ward in Mogotio sub county. His research title is ***" Assessment of factors influencing the level of implementation of community health strategy".***

Please accord him the necessary assistance.

Thank you

DIRECTOR OF EDUCATION
MOGOTIO SUB-COUNTY
BOX 91-20105, MOGOTIO
Date: 18/10/19

NYABERI ROBERT M.
SUB COUNTY DIRECTOR OF EDUCATION
MOGOTIO

APPENDIX X: AUTHORITY LETTER FROM MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL ADMINISTRATION-MOGOTIO SUB-COUNTY

THE PRESIDENCY

Telegrams: "SUB-COUNTY", Mogotio
Telephone: Mogotio
E-mail: dcmogotio@yahoo.com
dcmogotio@gmail.com
When replying please quote

MINISTRY OF INTERIOR AND
CO-ORDINATION OF
NATIONAL GOVERNMENT

Deputy county commissioner's office,
Mogotio Sub-County,
P.o. Box 16 - 20105
MOGOTIO.

Ref: MGT/CORR.3/1 VOL.1/177

Date: 18th October,2019

To whom it may concern.

RE: AUTHORITY LETTER FOR DATA COLLECTION FOR BARTENA KIMOSOP SAMUEL

The bearer of this letter is a student at Mt Kenya University who is undertaking a research study in three community units of Ngubereti,Koitebes and Sirwa in Mogotio ward in Mogotio Sub-County.His research title is Assessment of the factors influencing the level of implementation of community health strategy.

Kindly accord him any necessary assistance.

DEPUTY COUNTY COMMISSIONER
MOGOTIO SUB COUNTY

G. B Ondari,
For:Deputy County Commissioner,
Mogotio Sub-County.

APPENDIX XI : RESEARCH LICENSE

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **947315**

Date of Issue: **09/January/2020**

RESEARCH LICENSE

This is to Certify that Mr.. BARTENA SAMUEL of Mount Kenya University, has been licensed to conduct research in Baringo on the topic: ASSESSMENT OF FACTORS INFLUENCING THE LEVEL OF IMPLEMENTATION OF COMMUNITY HEALTH STRATEGY IN MOGOTIO SUB COUNTY,BARINGO, KENYA for the period ending : 09/January/2021.

License No: **NACOSTI/P/20/3172**

947315

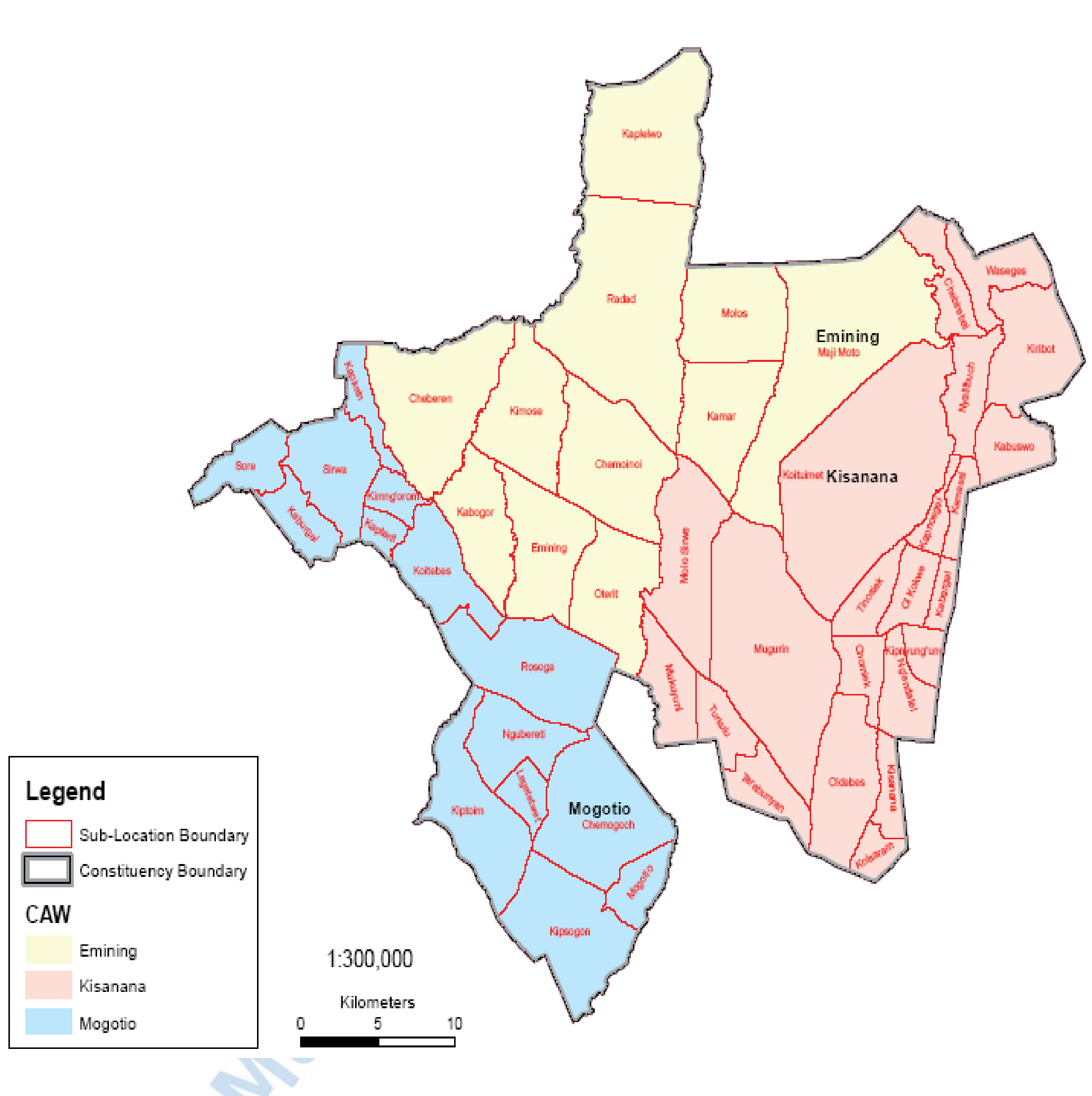
Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

APPENDIX XII : MAP OF THE STUDY AREA



Source -Internet; Google maps

APPENDIX XIII: SIMILARITY INDEX

Thesis

by Bartena Kimosop Samuel__

Submission date: 01-May-2023 10:15PM (UTC+0300)
Submission ID: 2081222603
File name: SAMUEL_KIMOSOP_Thesis_APRIL_2023.doc (8.83M)
Word count: 26315
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Thesis

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3/5/23

Mount K