

**FACILITATORS OF COMMUNITY HEALTH PROMOTERS SERVICE
PROVISION IN NANDI COUNTY**

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**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT
FOR THE DEGREE OF MASTER OF SCIENCE IN HEALTH SYSTEMS
MANAGEMENT, KENYA METHODIST UNIVERSITY.**

OCTOBER 2025

DECLARATION

I hereby declare that this thesis is my original work and has not been presented in any other University.

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DEDICATION

I dedicate this study to my beloved mother, Recho Terigi, my devoted husband Nicholas, and my precious children Caleb, Jabez, & Jonathan. Your unwavering love, steadfast encouragement, and enduring belief in me have been my guiding light throughout this academic journey. Every word of support, every act of patience, and every shared moment of hope have strengthened my resolve and inspired me to persevere. This accomplishment stands as a testament to your constant presence and boundless care.

I also dedicate this study to Mercy, our house manager, whose kindness, support, and dedication have been a quiet but invaluable source of strength and inspiration to succeed even when times were tough.

Finally, i dedicate this study to the cherished memory of my late father-in-law, Jonathan Cheruiyot. Though he is no longer with us, his wisdom, kindness, and enduring inspiration continue to illuminate my path. His legacy of encouragement, integrity, and love has left an indelible mark on my life and has been a quiet, guiding force behind this noble achievement.

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ABSTRACT

Community Health Promoters (CHPs) play a vital role in expanding access to primary healthcare services in rural areas of Kenya. This study examined the key facilitators of service provision by CHPs in Nandi County, focusing on security of tenure, capacity building, financial incentives, and the availability of essential supplies and commodities. A descriptive research design was adopted. The target population comprised 1,567 CHPs serving across six sub-counties in Nandi County. Using Cochran's formula, a sample of 306 respondents was determined through stratified sampling to ensure adequate representation. Data were collected using a structured Likert-scale questionnaire, which was pretested on 30 CHPs in Uasin Gishu County to ensure validity and reliability. A 93.8% response rate was achieved ($n = 287$). Descriptive analysis revealed moderate adequacy in working conditions across the four variables. Many CHPs cited unclear job contracts and a lack of employment assurance as demotivating factors. Capacity-building opportunities varied in frequency and quality, affecting service delivery. Irregular remuneration and delayed stipends were identified as major financial challenges. Additionally, the inconsistent availability of supplies and commodities disrupted service provision. Inferential analysis using Pearson correlation and multiple linear regression revealed significant positive associations between all four variables and service provision: security of tenure ($r = 0.441$, $p < 0.01$), capacity building ($r = 0.518$, $p < 0.01$), financial incentives ($r = 0.486$, $p < 0.01$), and supplies and commodities ($r = 0.529$, $p < 0.01$). Combined, these factors explained 47.3% of the variance in service provision ($R^2 = 0.473$, $F = 52.763$, $p < 0.000$). The findings indicate that CHPs with clear employment terms, continuous professional development opportunities, timely financial support, and adequate tools and materials provide higher levels of service. Strengthening these facilitators is essential for improving CHP performance and sustaining community health services in rural Kenya. The study recommends formalizing CHPs' contracts, institutionalizing capacity-building programs, ensuring predictable financial incentives, and enhancing supply chain systems to support universal health coverage goals.

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ABBREVIATIONS AND ACRONYMS

CHEWs:	Community Health Extension Workers
CHPs:	Community Health Promoters
CHVs:	Community Health Volunteers
HENNET:	Health NGO Network
ITNs:	Insecticide-Treated Nets
KEPH:	Kenya Essential Package for Health
MOH:	Ministry of Health
MOPHS:	Ministry of Public Health and Sanitation
OHS:	Occupational Health and Safety
RoK:	Republic of Kenya
SPSS:	Statistical Package for Social Sciences
UNICEF:	United Nations International Children's Emergency Fund
WHO:	World Health Organization

OPERATIONAL DEFINITIONS OF TERMS

Attrition Rate: The rate at which community health promoters leave their positions due to challenges like limited support or incentives.

Capacity Building: Training and equipping healthcare workers to improve their performance and deliver quality outcomes.

Community Health Promoters (CHPs): WHO (2007) defines Community Health Promoters (CHPs) as individuals who provide essential health education, preventive services, and basic healthcare at the community level to improve health outcomes and bridge gaps in access to healthcare.

Data Collection Instruments: Tools like structured questionnaires used to gather information for research and service evaluation.

Financial Incentives: Monetary rewards or compensation provided to CHPs to enhance motivation and service quality.

Health Care Gap: Shortages or inadequacies in healthcare services or workforce impacting the delivery of services.

Health Outcomes: Measurable changes in health status resulting from the provision of health services.

Logistical Barriers: Challenges in the availability and distribution of necessary supplies and equipment for CHPs.

Preventive Health Care: Measures taken to prevent diseases or injuries before they occur, such as immunizations and health screenings.

Promotive Health Care: Activities aimed at improving health and preventing diseases through community education and interventions.

Capacity Building: Capacity building refers to the process of strengthening individuals, organizations, and systems to improve skills, resources, and institutional effectiveness for sustainable development.

Financial Incentives: Financial incentives in a community health setup refer to monetary or material rewards provided to healthcare workers, volunteers, or beneficiaries to encourage behaviours that improve health outcomes and service provision.

Security of Tenure: Security of tenure in employment refers to the assurance that an employee can retain their position as long as they meet performance expectations and contractual obligations, without the risk of arbitrary dismissal.

Service Provision: In the context of health, service provision refers to the process of offering healthcare services to individuals or populations with the goal of promoting, preserving, and restoring health. This encompasses a range of services including preventive measures, treatment of illnesses, rehabilitation, and palliative care, delivered through both public and private healthcare systems.

Supplies and Commodities: Supplies and commodities refer to essential goods and materials required for service provision in the health care sector.

CHAPTER ONE

INTRODUCTION

1.1 Background Information

The World Health Organization (WHO, 2022) defines Community Health Promoters (CHPs) as individuals who provide essential health education, preventive services, and basic healthcare at the community level to improve health outcomes and bridge gaps in access to healthcare. Community Health Promoters (CHPs), also known as Community Health Volunteers (CHVs), are trained individuals selected from the communities they serve. They deliver essential primary healthcare services such as health education, referrals, home visits, and data collection under the supervision of Community Health Assistants (CHAs). CHPs typically serve a defined number of households, often 100 per CHP, promoting preventative and promotive health interventions. They often work within primary healthcare systems to promote disease prevention, maternal and child health, and other public health interventions (United Nations International Children's Emergency Fund [UNICEF], 2021; Ministry of Health [MOH], 2023).

Community Health Promoters (CHPs) are integral to advancing health promotion and prevention within community-based primary healthcare systems. Their role has become increasingly significant because of the global shortage of health professionals, that has heightened reliance on CHPs to address societal healthcare needs. This deficit affects essential health workers such as midwives, nurses, and physicians, particularly in resource-limited settings where healthcare needs are on the rise (World Health Organization [WHO], 2023; Barasa et al., 2021). Concurrently, disease burden continues to escalate in these regions, both communicable and non-communicable diseases. World Health Organization (WHO) has consistently highlighted the need to address this

shortage. According to the WHO (2023), the lack of professional health workers remains one of the primary factors in the growing human resource crisis, particularly in low-income countries. The report recommended task-shifting as a viable strategy, advocating the delegation of specific responsibilities to CHPs who are trained to perform such tasks effectively. This approach has since been widely adopted in various healthcare systems globally (WHO, 2022; Lusambili et al., 2021).

CHPs are essential contributors to global health, as evidenced by their widespread presence and impact. According to UNICEF (2021), there are over 1.3 million CHPs worldwide who provide critical support in healthcare delivery. Their efforts serve more than 163 million vulnerable children, including millions orphaned by HIV and AIDS, the majority of whom reside in Sub-Saharan Africa, a region that carries a large portion of the global disease burden but is served by only a small percentage of the world's health workforce (WHO, 2023; Kamau et al., 2024). This imbalance illustrates the significant challenges in healthcare access and service provision faced by the region (World Bank, 2020; Barasa et al., 2021).

A case example of South Africa provides a stark example of how historical inequities have exacerbated healthcare disparities. The legacy of apartheid resulted in the uneven distribution of healthcare resources, leaving many communities underserved (Mutua et al., 2023). These challenges have been compounded by the migration of skilled health workers to higher-income countries offering better pay and improved working conditions (World Bank, 2020; WHO, 2023). This trend further deepens the healthcare crisis in resource-constrained regions and highlights the urgent need for innovative solutions to strengthen healthcare delivery systems (United Nations Development Programme [UNDP], 2022; WHO, 2023).

To address these pressing challenges, there has been a concerted effort to increase the training and deployment of CHPs. These individuals are central to models designed to enhance access to healthcare in underserved regions while contributing to sustainable improvements in global health outcomes (Kamau et al., 2024; MOH, 2023). CHPs also play a crucial role in mitigating severe shortage of healthcare workers, which continues to hinder progress in primary healthcare services. Their integration into health systems not only expands the healthcare workforce but also offers a cost-effective solution to meeting the health needs of marginalized populations (WHO, 2023; Kiplagat et al., 2023; Odhiambo et al., 2022).

Investing in CHPs is essential for improving healthcare service provision and achieving universal health coverage. These health promoters serve as a bridge between communities and formal healthcare systems, delivering essential services and building trust among vulnerable populations (UNICEF, 2021; WHO, 2022). By addressing gaps in human resources for health, CHPs contribute to strengthening healthcare systems and advancing global health equity (Kamau et al., 2024; Lusambili et al., 2021).

Community Health Promoters have emerged as vital components in the provision of healthcare services, especially in rural and underserved regions. Globally, this has been recognized as an essential part of the healthcare workforce, addressing critical health needs in areas where access to formal healthcare services is limited (UNDP, 2022; WHO, 2021). World Health Organization (WHO) underscores the significance of achieving Universal Health Coverage (UHC) by bringing health services closer to communities (WHO, 2023). This situation is compounded by the scarcity of continuous education opportunities, leaving CHPs without the necessary updates on evolving health practices and protocols (Kiplagat et al., 2023; Kamau et al., 2024).

In Sub-Saharan Africa, including Kenya, Community Health Promoters (CHPs) have been instrumental in the fight against major health challenges such as HIV/AIDS, malaria, and maternal and child mortality (Awuor & Kinyanjui, 2023; Lusambili et al., 2021; WHO, 2023). CHPs are instrumental in bridging the gap between formal healthcare systems and the community, providing essential services such as health education, disease prevention, and basic medical care (UNICEF, 2021; MOH, 2020). Despite their importance, CHPs face numerous challenges that hinder their effectiveness in health service provision (Lusambili et al., 2021; Odhiambo et al., 2022; Kiplagat et al., 2023). Over the years, communities and patients have relied on healthcare promoters in addressing critical healthcare issues such as crucial health practices that include immunization, childbirth, pregnancy, infectious diseases, and various challenges faced by households (Pradhan & Adhikari, 2022; WHO, 2023). To address these challenges, the country implemented the Kenya Community Strategy for Health (MOH, 2020) which relies on Community Health Promoters (CHPs) as key agents in fostering behaviour change. These lay volunteers play a crucial role in delivering health education, identifying cases early, and facilitating timely referrals to trained medical personnel. This approach is based on evidence demonstrating that task-sharing can be both feasible and effective in enhancing health behaviours within communities (Kamau et al., 2024; Lusambili et al., 2021).

The current Kenya Community Health Strategy (2020–2025) further builds on this foundation by establishing functional Community Health Units (CHUs), each covering approximately 5,000 people. Each unit is served by about 50 CHPs responsible for roughly 20 households each. The strategy emphasizes integration of CHPs into the formal health system, standardization of training and remuneration, improved commodity supply chains, and the use of digital health tools such as

the electronic Community Health Information System (eCHIS) to enhance data collection and service delivery (MOH, 2020; Njuguna et al., 2021; Kamau et al., 2024; WHO, 2023).

Community Health Promoters (CHPs) in Kenya play a critical role in improving healthcare service provision, including family planning. Since the 1980s, most CHPs have received training from non-governmental organizations (NGOs) within the framework of primary health care (UNICEF, 2021; Lusambili et al., 2021). However, government support and recognition for these health promoters have remained minimal, leaving NGOs to shoulder the responsibility of training and supporting them (MOH, 2021; Odhiambo et al., 2022). The MOH (2021) highlights the challenging conditions faced by CHPs, particularly in rural areas. Many regions have difficult terrains, requiring CHPs to travel long distances, often on foot or bicycles, to reach patients (Barasa et al., 2021; WHO, 2023). These arduous journeys delay service provision and contribute to burnout and reduced morale. Furthermore, CHPs frequently work without essential medical supplies, such as gloves, medications, and testing kits, severely limiting their capacity to deliver comprehensive care (Odhiambo et al., 2022; UNICEF, 2021; MOH, 2023). This lack of resources underscores the pressing need for better logistical support and resource allocation (Kiplagat et al., 2023; Kamau et al., 2024).

Nandi County, characterized by its diverse and largely rural population, exemplifies the challenges CHPs face. The county's terrain, coupled with logistical difficulties, inadequate healthcare infrastructure, and cultural barriers, creates significant obstacles for CHPs (Nandi County Department of Health, 2023; Lusambili et al., 2021). Despite having approximately 242 healthcare facilities across six sub-counties, only 63% fall under the Ministry of Health, while the remainder are managed by faith-based organizations, private entities, or other frameworks (MOH, 2023;

WHO, 2023). This fragmentation complicates coordination and strains CHPs, who are instrumental in bridging gaps in healthcare service provision (Kamau et al., 2024; Barasa et al., 2021).

The high population in Nandi County further exacerbates these challenges, straining the healthcare system and the CHPs who operate within it (Nandi County Department of Health, 2023; WHO, 2023). CHPs help in raising awareness and delivering essential services in hard-to-reach areas, yet their efforts remain hindered by poor working conditions and limited recognition (Odhiambo et al., 2022; Lusambili et al., 2021; Kiplagat et al., 2023). This study sought to delve into the experiences of CHPs in Nandi County, exploring the challenges they encounter and proposing actionable solutions to enhance their effectiveness (Kamau et al., 2024; WHO, 2022). Addressing these issues is critical for strengthening primary healthcare systems and improving health outcomes in the region (WHO, 2023; Barasa et al., 2021).

Despite their critical role in healthcare service provision, Community Health Promoters in Nandi County face numerous challenges that hinder their ability to provide effective services (Lusambili et al., 2021; Odhiambo et al., 2022; WHO, 2023). These challenges, which include inadequate training, logistical barriers, limited financial support, and cultural constraints, not only affect the health outcomes in the community but also contribute to high attrition rates among CHPs (Kiplagat et al., 2023; Kamau et al., 2024). Understanding these challenges from a local perspective is important to help guide the development of targeted contextual interventions that can improve the sustainability and impact of CHPs in Nandi County (Nandi County Department of Health, 2023; MOH, 2023). Moreover, coming to terms and understanding problems faced by community health

promoters will be vital for healthcare providers, policymakers, and stakeholders such as the national government towards supporting them accordingly (Lusambili et al., 2021; WHO, 2023).

1.2 Statement of Problem

The persistent shortage of healthcare workers remains a significant barrier to achieving Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs) in low- and middle-income countries, including Kenya. Community Health Promoters (CHPs) have been deployed nationally as a strategic response to bridge this gap by extending essential healthcare services to communities. Despite their critical role, the sustainability and long-term impact of CHPs on healthcare outcomes remain uncertain, largely due to inconsistent service provision and inadequate support mechanisms. Existing evidence demonstrates that various factors influence the effectiveness of healthcare service delivery, including workforce stability, capacity-building opportunities, financial motivation, and the availability of essential supplies. In many settings, including Nandi County, CHPs face challenges such as unclear employment terms, irregular remuneration, inadequate training, and frequent stockouts of commodities. These gaps undermine their ability to deliver consistent, high-quality services to communities.

Although the CHP model is central to Kenya's community health strategy, there is limited empirical evidence on the specific factors that enable effective service provision in the local context of Nandi County. Understanding these enablers is crucial for designing targeted interventions that enhance CHP performance and contribute to the realization of UHC and the SDGs. This study, therefore, sought to examine the key facilitators of security of tenure, capacity building, financial incentives, and the availability of supplies and commodities that influence CHP service provision in Nandi County.

1.3 Purpose of the Study

The purpose of the study was to explore the factors that enhance the provision of services by Community Health Promoters (CHPs) in Nandi County. The study aimed to generate insights into the enablers that improve both the quality and sustainability of services provided by CHPs, thereby contributing to better health outcomes in the community. By examining key elements such as security of tenure, capacity building, financial incentives, and the availability of essential supplies and commodities, the research sought to identify practical strategies for strengthening healthcare service provision in the county.

1.4 Objectives of the Study

1.4.1 General Objective

The main objective of this study was to determine the facilitators of community health promoters service provision in Nandi County.

1.4.2 Specific Objectives

The following specific objectives guided the study:

- i. To assess the role of security of tenure of CHPs in Service provision in Nandi County
- ii. To analyze the role of Capacity building of CHPs in service provision in Nandi County
- iii. To assess the role of financial incentives for CHPs in service provision in Nandi County
- iv. To examine the influence of essential supplies and commodities on the effectiveness of service delivery by Community Health Promoters in Nandi County

1.5 Research Questions

The study's main aim was to answer the following questions

- 1) What is the role of the security of tenure of CHPs in service provision in Nandi County?
- 2) What is the role of capacity building of CHPs in service provision in Nandi County?
- 3) What is the role of financial incentives for CHPs in service provision in Nandi County?
- 4) What is the influence of essential supplies and commodities on the effectiveness of service delivery by Community Health Promoters in Nandi County?

1.6 Justification of the Study

Creswell and Creswell (2023) define justification of the study as the rationale for conducting the research, demonstrating its significance, relevance, and contribution to existing knowledge. It addresses gaps in the literature, practical applications, or theoretical advancements. Community Health Promoters (CHPs) are critical in bridging gaps between healthcare systems and underserved populations. However, in Nandi County, numerous challenges such as inadequate training, lack of resources, cultural constraints, and logistical barriers hinder CHPs' effectiveness. To enhance the sustainability and impact of CHPs on health outcomes in the community, addressing these issues is essential. This study was justified by the need to provide empirical data that informs policymakers, healthcare providers, and stakeholders about the facilitators that improve CHPs' service provision. Insights gained contributed to the development of targeted interventions, ensuring the sustainability of primary healthcare systems in rural areas and aligning with global health objectives like Universal Health Coverage (UHC). The study also aimed to bridge gaps in existing academic literature by providing context-specific findings for Nandi County, Kenya, serving as a reference for similar healthcare settings nationally and globally.

1.7 Significance of the Study

“Significance of the Study” refers to the section of a research paper that explains the potential contributions of the study to theory, practice, or policy. It highlights how the findings benefited specific stakeholders, such as researchers, practitioners, policymakers, or communities (Creswell & Creswell, 2018). The study on the facilitators of Community Health Promoters (CHPs) service provision in Nandi County was crucial for several reasons. First, it provided insights into the challenges faced by CHPs, such as inadequate training, logistical barriers, limited financial support, and cultural constraints. By addressing these challenges, the study aimed to enhance the sustainability and impact of CHPs, thereby improving health outcomes in the community.

Second, the findings were invaluable to policymakers, healthcare providers, and stakeholders, including the national government, in formulating targeted interventions to support CHPs effectively. This support can strengthen healthcare systems, particularly in underserved areas, aligning with global health goals like Universal Health Coverage.

Lastly, the study contributed to academic literature by identifying specific facilitators such as security of tenure, capacity building, financial incentives, and the provision of supplies and commodities that can improve the quality-of-service provision. The outcomes served as a reference for future research and policy development aimed at optimizing primary healthcare in Kenya and similar contexts globally.

1.8 Assumptions of the Study

Research study assumptions refer to underlying beliefs or conditions that researchers accept as true without direct proof, which influence the study's design, methodology, and interpretation of results

(Saunders et al., 2023). These assumptions may relate to the population, data collection methods, or theoretical frameworks guiding the research.

This study operated under several key assumptions. It assumed that the respondents, particularly Community Health Promoters (CHPs), will provide accurate and honest responses regarding the factors influencing their service provision. Additionally, it is presumed that security of tenure, capacity building, financial incentives, and access to necessary supplies and commodities have a significant role in enhancing the effectiveness and sustainability of CHPs service provision. Stratified sampling technique was expected to capture the diverse characteristics of CHPs in Nandi County, ensuring the generalizability of the study findings. Furthermore, this research study assumed that the external environment and factors affecting CHPs will remain stable throughout the data collection period, minimizing potential biases in analysing the facilitators of service provision.

1.9 Limitation of the study

The study encountered several limitations that may have affected the scope and generalizability of its findings. Financial and logistical constraints limited the extent of data collection, particularly in remote areas of Nandi County. To address this challenge, priority was given to high-impact regions and participants, and support was sought from local organizations, including the County Government of Nandi, to facilitate fieldwork.

Some Community Health Promoters (CHPs) did not respond to the questionnaire due to heavy workloads and personal commitments, which affected the comprehensiveness of the data. To minimize non-response, flexible data collection schedules and alternative methods, such as online or phone interviews, were employed. Variations in language and literacy levels among respondents

also presented challenges in understanding some questionnaire items. This was mitigated through pretesting of research instruments to identify ambiguous wording and through translation of the questionnaires into local languages commonly spoken in the study area. Trained research assistants, fluent in both English and local languages, administered the questionnaires and provided necessary clarifications while maintaining consistency in interpretation. Where literacy barriers were identified, an interviewer-administered approach was used to ensure accurate responses.

The study findings are specific to Nandi County and may not be entirely generalizable to other regions with different socio-economic and cultural contexts. However, the insights provide a useful basis for understanding factors that influence service provision by Community Health Promoters in similar rural settings.

1.10 Research Delimitations

Research delimitations define the boundaries of a study, specifying what is included and excluded based on the researcher's choices. These may include the selected population, geographic area, variables, or theoretical framework (Creswell & Poth, 2023). Delimitations help focus the study while clarifying its scope and applicability. This study focused specifically on the facilitators of CHP service provision in Nandi County, excluding other counties or healthcare cadres. The target population was limited to CHPs, excluding other healthcare workers or stakeholders involved in community health services. The research was confined to Nandi County, which was chosen due to its unique challenges and opportunities in healthcare service provision. The study examined security of tenure, capacity building, financial incentives, and supplies as the primary facilitators, excluding other possible factors. The research used structured questionnaires as the sole data collection tool, excluding interviews or focus groups.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Literature review is fundamental in establishing the theoretical and empirical basis for understanding the facilitators of Community Health Promoters (CHPs) service provision. This chapter delves into existing studies, frameworks, and theories relevant to the research, providing insights into how various factors such as security of tenure, capacity building, financial incentives, and access to supplies and commodities affect CHPs' effectiveness in Nandi County. By reviewing both global and local perspectives, this chapter aims to contextualize the unique challenges and opportunities within the Kenyan healthcare system, highlighting the critical role of CHPs in enhancing primary healthcare outcomes.

The chapter begins by exploring the broad concept of community service provision, followed by an analysis of the specific facilitators identified in the study. Theoretical and conceptual frameworks are employed to anchor the discussions, ensuring a robust foundation for the research. Finally, an empirical review identifies existing knowledge gaps, underscoring the necessity for this study in advancing targeted interventions to optimize CHP service provision.

2.2 Service Provision

The Kenya Community Health Strategy (2020–2025) prioritizes empowering households to take responsibility for improving their health, as households form the cornerstone of cost-effective, equitable, and efficient healthcare delivery systems (MOH, 2020). Kenya Essential Package for Health (KEPH) outlines the guidelines on healthcare norms and standards. Level 1 services encompass promotive, preventive, and basic curative care. These services are structured to serve populations of approximately 5,000 individuals through the efforts of 50 Community Health

Promoters (CHPs), each identified and trained within their community to deliver services to 20 households (Njuguna et al., 2021).

The current Community Health Strategy (2020–2025) aligns with Kenya’s Universal Health Coverage (UHC) agenda and broader health-sector reforms. It emphasizes integrating CHPs into formal health systems, strengthening supply chains, and improving supervision through Community Health Assistants (CHAs). These strategic efforts reflect ongoing government commitments to institutionalize community health as a core component of primary healthcare, moving away from NGO-led programs toward sustainable county-led approaches. This study ties directly into these ongoing efforts by examining the specific facilitators such as job security, capacity building, financial incentives, and supply availability that determine how effectively CHPs can implement the strategy at the community level (MOH, 2020; Kamau et al., 2024).

However, significant challenges persist regarding the effectiveness of CHPs in fulfilling their roles. Key concerns include their limited educational background, the impact of socio-political and economic dynamics, and the geographic distribution and size of the populations they serve (Ochieng et al., 2022). These factors directly affect the quality of care CHPs can provide, sparking debates about the appropriate scope of their duties. For instance, the WHO (2022) has emphasized the need for evidence-based policies to determine the optimal number of functions CHPs can effectively perform. Moreover, a study by Awuor and Kinyanjui (2023) highlights gaps in training and resource allocation that limit the effectiveness of CHPs, necessitating a reassessment of their operational frameworks. Strengthening evidence-based approaches and addressing systemic challenges are crucial to enhancing the impact and sustainability of community health strategies (Kamau et al., 2024).

The primary objective of the Community Strategy is to improve healthcare access at the community level, ultimately enhancing individual productivity while addressing issues such as poverty, hunger, maternal and child mortality, and educational outcomes (UNDP, 2021). Community Health Promoters (CHPs) play a crucial role, particularly in regions with limited access to facility-based healthcare services (Odhiambo et al., 2022). For instance, CHPs contribute to expanding healthcare accessibility and utilization while supporting key health initiatives, including primary healthcare, tuberculosis management, immunization, and family-planning programs (Lusambili et al., 2021).

Despite ongoing efforts to improve service quality, significant challenges persist, preventing substantial progress in many healthcare institutions. Limited financial resources often hinder the ability to procure necessary medical supplies, while job insecurity among community health promoters affects their motivation and performance (Chepkemai et al., 2024). Additionally, inadequate training and capacity-building programs reduce the efficiency and effectiveness of healthcare service providers, CHPs included, ultimately negatively impacting the quality of care (Kiplagat et al., 2023).

A major barrier to addressing these challenges is the lack of comprehensive information on the specific factors that hinder service provision. Without a deeper understanding of these constraints, it becomes difficult to implement effective interventions. Addressing these issues through better resource allocation, improved working conditions, and enhanced training programs is crucial for ensuring high-quality healthcare services (Awuor & Kinyanjui, 2023; WHO, 2023).

Abubakar and Odeyemi (2022) examined the link between perceived service quality and community satisfaction, concluding that perceived service quality significantly impacts

satisfaction with healthcare delivery. Moreover, in service-related industries, perceived service quality plays a more critical role in client satisfaction than perceived cost. While definitions may vary, there is a consensus that perceived service quality pertains to the overall assessment of community health services based on expectations and perceived performance levels (Muleya et al., 2021).

Several fields and sectors have been explored to evaluate perceived service quality (Abubakar & Odeyemi, 2022). The most widely recognized framework is the one introduced by Parasuraman et al. (2021) which consists of five dimensions: reliability, assurance, tangibles, empathy, and responsiveness. Recent studies, such as that by Ochieng et al. (2022) have applied these dimensions within public healthcare in Kenya to assess patient and community satisfaction. In the healthcare industry, perceived service quality has been extensively analyzed, particularly in community-based and public healthcare settings, where the SERVQUAL model has been adapted to emphasize empathy, reliability, and responsiveness as key predictors of satisfaction (Odhiambo et al., 2022; Gitobu et al., 2023).

2.3 Security of Tenure

The Kenya Health Policy (2014–2030) acknowledges the critical role played by Community Health Promoters (CHPs) in providing basic essential health services at the community level. According to the policy, CHPs undertake multiple responsibilities, including informal community programs and home-based health interventions. Over time, there has been a significant shift, with much of the responsibility for preventive health now placed on CHPs, who serve as crucial links between communities and local health facilities (MOH, 2023; WHO, 2023). This decentralized approach is designed to strengthen healthcare systems by integrating community-based services

into the broader health structure, ensuring that primary healthcare reaches the most vulnerable populations (Kamau et al., 2024).

As an extension of formal healthcare systems, Community Health Strategy (CHS) interventions play a pivotal role in bridging the gap between households and medical facilities. These interventions primarily focus on identifying vulnerable households, conducting home visits, and providing essential care at the community level. According to the Kenya Essential Package for Health (KEPH), CHPs are responsible for delivering Level 1 services, which include household monitoring, caregiving for sick family members, and managing referrals to and from local health facilities (MOH, 2020; Njuguna et al., 2021). These responsibilities highlight the integral role CHPs play in the holistic delivery of healthcare services, reinforcing their importance in achieving equitable access to healthcare in Kenya (Lusambili et al., 2021).

Evidence suggests that CHPs are particularly effective in bridging the gap between communities and healthcare facilities. Their contributions include disseminating health information, assessing illnesses, and facilitating timely referrals (Awuor & Kinyanjui, 2023; Kiplagat et al., 2023). This approach not only enhances access to healthcare but also improves health outcomes by addressing preventable conditions at the community level. Recent studies underscore the value of CHPs in reducing healthcare disparities and fostering community engagement in health promotion efforts (Gatumi et al., 2022; Chepkemai et al., 2024).

CHPs are instrumental in promoting preventive health practices, which are vital in achieving universal health coverage goals (WHO, 2023; UNDP, 2021). Their integration into health systems ensures the delivery of cost-effective, sustainable, and culturally appropriate healthcare (Kamau et al., 2024; Lusambili et al., 2021). By strengthening community linkages, CHPs significantly

contribute to improved healthcare service provision in Kenya (Odhiambo et al., 2022; Awuor & Kinyanjui, 2023).

2.4 Capacity Building

Skilled professionals play a critical role in ensuring quality outcomes, thereby driving the growth and success of hospitals (WHO, 2021). In public sector hospitals, building capacity to attract and retain enough qualified health care professionals is crucial for improving efficiency in service provision. The ability to adapt to the dynamic healthcare environment is a key determinant of long-term success, as the most effective organizations are those that embrace change and innovation rather than merely striving for immediate gains in market share (WHO, 2021; Kotler & Keller, 2022). Hospitals must invest in capacity-building initiatives that continuously develop their workforce's skills and competencies to match the demands of evolving healthcare systems (Gatumi et al., 2022).

Service quality in hospitals often suffers due to a combination of seemingly minor events stemming from inadequate employee capacity. Effective service provision necessitates specific skill levels, experience, and continuous learning to address these gaps (Gatumi et al., 2022). Organizations that remain open to new knowledge and insights from their environment are better equipped to innovate and adapt to challenges. Furthermore, managing service provision requires hands-on leadership that involves engaging with staff and patients, understanding their concerns, and implementing solutions to address systemic issues (George et al., 2020; Campbell et al., 2022).

2.5 Financial Incentives

Fixed budgets are a commonly used financial management approach in healthcare systems, particularly in hospitals, and are often based on historical expenditure levels with minimal adjustments for inflation or changes in costs. While they provide a simple mechanism for expenditure control and administrative ease, they could also promote historical inequities and fail to adapt to evolving demands and priorities, limiting the responsiveness of healthcare systems (Commonwealth Fund, 2022; WHO, 2023). Fixed budgets frequently offer limited incentives for hospitals to enhance the quality, efficiency, or quantity of services provided, but their rigid structures can restrict resource optimization at local levels (European Observatory on Health Systems and Policies, 2022).

Centralized fixed budget systems, wherein funding is controlled by central ministries, often fail to grant peripheral levels the flexibility to allocate resources based on local needs. This approach risks perpetuating inefficiencies and can undermine the quality of care by limiting local managerial discretion (Global Healthcare Initiative, 2023; Barasa et al., 2021). The lack of flexibility is particularly concerning in resource-constrained settings, such as rural areas, where hospitals struggle to meet basic healthcare demands (Republic of Kenya, 2022; WHO, 2023).

Alternative budgetary models, such as global budgets or volume-adjusted frameworks, have been proposed as solutions to some of these challenges. Global budgets provide a fixed amount for all services over a defined period, encouraging hospitals to focus on efficiency, cost management, and preventive care (Commonwealth Fund, 2022; OECD, 2023). However, these models require mechanisms to ensure service quality and equity, as they may otherwise incentivize cost-cutting at the expense of patient care (Global Healthcare Initiative, 2023; UNDP, 2021).

In Kenya, healthcare systems have historically suffered from underinvestment, with public hospitals in rural areas often unable to deliver adequate services. Recent reforms, including economic stimulus programs, aim to address these gaps, but significant challenges remain in aligning funding mechanisms with healthcare needs (MOH, 2023). Modern approaches advocate for participative financial management in healthcare, emphasizing strategic planning, quality control, and sustainable funding to enhance service provision and community health outcomes (WHO, 2023; Barasa et al., 2021; Kisia et al., 2024).

To improve outcomes, healthcare systems must embrace adaptive budgeting practices that align resource allocation with both immediate patient care needs and long-term health system sustainability. These include integrating community health initiatives and leveraging technology to improve resource utilization and service provision (Commonwealth Fund, 2022; WHO, 2023).

2.6 Supplies and Commodities

Community Health Promoters (CHPs) require consistent access to essential supplies, medicines, and equipment to perform their duties effectively. However, disruptions in the supply chain often undermine their productivity and result in adverse outcomes, such as eroding community trust, which is critical for the effectiveness of CHPs and highlights the pivotal role of reliability in ensuring CHPs' success in providing health services (Mutisya, 2021).

The effectiveness of CHPs also depends on the availability of safety and medical supplies to address common community health needs. These supplies include disinfectants like Jik, gloves, and first aid essentials such as glucose powder, gentian violet, foldable hand stretchers, crêpe bandages, and firm liniment ointment. Additionally, drugs for managing common ailments, such

as oral rehydration salts, tetracycline eye ointment, multivitamins, and Nutri Fit, are vital for community case management (MOH, 2020).

According to the Ministry of Health (2020), preventive and promotive health initiatives necessitate specific resources, including insecticide-treated nets (ITNs), water purification agents like Water Guard, contraceptives, condoms, treatment protocols, and indoor residual spraying tools. Additionally, vital supplies such as soap, growth monitoring instruments, and educational materials for health awareness are essential. These resources collectively support the promotion of healthier behaviours and prevent the spread of diseases within communities (UNICEF, 2023).

To maintain operational effectiveness, it is imperative to address supply chain gaps and invest in reliable systems to ensure the uninterrupted provision of materials. Recent studies emphasize the importance of digitized logistics management information systems (LMIS) and county-level forecasting to minimize stock-outs and improve last-mile delivery (Ministry of Health, 2021; United States Agency for International Development [USIAD], 2020; Alonge et al., 2022). Strengthening commodity security and logistics support enhances CHPs' productivity and fosters community trust, which is critical for successful health interventions (Barasa et al., 2021).

CHPs need essential support, including transportation (such as bicycles and motorcycles), communication tools like mobile phones and airtime, and advocacy materials such as banners. They also require a bag, a battery-powered torch with extra batteries, and data collection supplies, including pens, notebooks, referral forms, and reporting tools (MOH, 2023). However, many issues persist regarding the inadequate provision of supplies and logistical support for CHPs. These shortages are largely attributed to poor planning, often resulting from limited planning capacity, insufficient funding, and a lack of awareness regarding budget constraints. Consequently, these

challenges have been associated with high attrition rates among CHPs within the community (Wambui, 2022).

2.7 Theoretical Framework

2.7.1 Resource Mobilization Theory (RMT)

Resource Mobilization Theory (RMT) posits resourcing capacity as the determining factor for actualization of an organizational or programmatic agenda whether in terms of funding, human capital, social capital, or material resources. Developed in the framework of social movement organizations by McCarthy and Zald (1977) RMT argues that the viability of any venture can be defined by the extent to which it coordinates, maintains, and deploys resources. It postulates that it is not only important for programs to have resources but also the way resources are mobilized, deployed or provided impacts on programs sustainability success and effectiveness.

Regarding CHPs, RMT becomes a lens through which one would understand the changes in service provision brought about by availability of new resources such as funding, equipment and transport among others. For instance, keeping adequate and timely funding intact which also allows CHPs to regularly receive their remunerations is immensely important as it helps to give them the motivation and commitment. Unlike being economically strained, financial stability gives CHPs the needed capacity to perform their duties without relieving pressure from financial difficulties. In that case, it also allows for the acquisition of medical resources that facilitate their ability to provide adequate healthcare to populations that may lie outside urban centres.

RMT also points to the potential of Social Capital motivating the building of community trust and collaboration with healthcare workers. Trust is a critical and unique organizational asset that helps the CHPs to initiate and promote increased use of health services among people and households.

There is improvement in the placing of referrals and access to other healthcare facilities that has resulted in the enhancement of service provision.

RMT also emphasizes that system factors that may hinder CHPs' performance are the structural barriers. Difficulties like lack of funding, source contention and lack of training denotes poor resource mobilization and resource deployment. If these concerns are considered, policymakers as well as program managers are in a better position to accord proper utilization of resources hence promoting sustainability and efficiency of the community health programs. Thus, RMT serves as a guiding framework for understanding and overcoming structural challenges, ensuring resources are mobilized and utilized to their fullest potential.

2.7.2 Social Determinants of Health (SDH) Framework

Figure 2. 1

Social Determinants of Health Framework (WHO,2010)



The WHO (2023) describes the SDH Framework as encompassing the key social factors that affect the state of health of a population. Determinants such as income, education, geography, and access to healthcare help predict the health of individuals and communities. The framework demonstrates that people's health is influenced not only by medical factors but also by the broader social context in which they live.

Regarding Community Health Promoters (CHPs), the framework helps in analyzing external factors that impact service provision. For example, since most people in rural areas are from low-income brackets, they are likely to lack adequate transportation, communication equipment, supplies, and medication. Some CHPs operate in geographically isolated areas with limited access to electricity, communication, and transportation, adversely impacting the quality of service provision to target populations (MOH, 2023).

Another factor that affects workforce performance is training (capacity building) and tenure of employment (security of tenure). Training ensures CHPs develop essential skills, while job security motivates them to serve their communities more effectively (Kamau et al., 2024). Moreover, both societal culture and the characteristics of the neighbourhoods in which CHPs operate affect their interactions with households and their ability to support health programs. For instance, traditional belief systems related to practices such as immunization or family planning often pose challenges to CHPs (Gatumi et al., 2022).

This is well explained by the SDH Framework because it emphasizes the need for targeted interventions to address disparities in access to healthcare facilities. Positioning CHPs as strategic actors within the health system underlines the importance of health system promotion strategies that cultivate enabling environments to help CHPs perform optimally and remain healthy. As

CHPs understand the social and economic challenges that hinder their functioning, this framework ensures that effective strategies to enhance community-level health outcomes are continually developed (WHO, 2021).

Resource Mobilization Theory (RMT) together with the Social Determinants of Health (SDH) Framework underpin a sound theoretical foundation to explain and address factors that influence CHPs' service delivery. While RMT focuses on the efficient use and mobilization of resources, the SDH framework highlights the broader systemic and contextual factors affecting CHPs' performance. Together, these theories offer a multidimensional approach to enhancing the effectiveness and sustainability of community health programs.

2.8 Empirical review

The study of service provision by Community Health Providers (CHPs) and its evaluation has garnered significant attention from scholars over the last two decades. In this domain, two primary viewpoints on measuring service provision have emerged: a systems-performance approach and a client-perception approach (Mutua et al., 2020). Recent analyses indicate that researchers typically align with one of these two frameworks in their assessments (Oduor, 2021). The systems-based viewpoint includes additional factors beyond just the service provision process itself. For example, Onyango (2018) highlighted that client-perceived healthcare quality encompasses three dimensions: technical (the outcomes the service provides), image (the client's perception of the provider), and functional (the service provision process). Based on these dimensions, service quality is determined by two key variables: expected service and perceived service. High-quality service outcomes and effective service provision are significantly influenced by the competence of medical professionals, administrators, nurses, and other staff members. A challenge arises in

the selective recruitment of qualified personnel. The successful hiring and retention of staff are closely linked to empowering employees, treating them as equal partners in healthcare delivery, and offering opportunities for career advancement.

According to Njuguna et al. (2021), for CHPs to effectively provide services, there must be four key commitments: a willingness to invest in information systems, collaboration with staff and stakeholders to adapt systems that align with the institution's unique needs and culture, fostering buy-in to ensure the realization of benefits, and creating data systems that deliver real-time feedback to service providers. Public hospitals focused on quality service are characterized by strong commitment from leadership. This is evident through leaders who lead by example, dedication to investing in skilled staff, robust processes, and supportive tools, as well as a system-wide commitment to go beyond surface-level metrics to identify the root causes of service provision challenges and persistently work toward solutions (Kiptoo et al., 2022).

2.9 Summary and Gaps

There has been a growing emphasis on patient satisfaction in healthcare Oduor (2021) however, research focusing on patients' perceptions of service provision dimensions specifically by Community Health Promoters (CHPs) remains limited. This gap is significant, as the quality of care is a fundamental concern within healthcare systems. While traditional service quality dimensions, reliability, responsiveness, assurance, empathy, and tangibles, were originally identified decades ago, healthcare settings tend to involve a broader and more complex set of service delivery dimensions. These include not only reliability, tangibles, assurance, empathy, and responsiveness, but also factors such as food services, access to care, treatment outcomes, and the processes of admission and discharge. Furthermore, healthcare patients often prioritize core

service attributes, such as reliability and clinical outcomes, over peripheral aspects, including food, access, and tangible elements (Njoroge, 2021).

Recent studies have shown that patients from different geographic, demographic, and behavioural backgrounds have unique healthcare needs and expectations. These differences lead them to perceive various quality aspects of healthcare services in diverse ways, influenced by their individual circumstances. As a result, patients prioritize specific service quality dimensions and factors they consider most important (Mutua et al., 2023).

The empowerment of Community Health Promoters (CHPs) is a concept that has gained traction over time. From its early presence in public health campaigns and policy briefs, it has now become a central focus in governmental and county-level policy documents, such as the Kenya Community Health Strategy (2020–2025). Despite this, the discussions surrounding the empowerment of CHPs and the management of health programs in communities remain ongoing, with no clear consensus on the best approach. While the empowerment of CHPs is widely accepted, its practical implementation has encountered several challenges.

Recent studies highlight the importance of considering pre-qualification and competency testing before appointing CHPs. They also suggest that providing continuous support, supervision, and ensuring that CHPs have at least a secondary level of education can significantly improve their performance (Chepkemai et al., 2024; Lusambili et al., 2021). Furthermore, Awuor and Kinyanjui (2023) emphasize the necessity of promptly supplying CHPs with essential materials such as bags, kits, and reporting tools, and balancing their workload to enhance the quality of care provided. Although methods for empowering CHPs in the execution of health projects have been discussed

for some time, gaps still exist, and further clarification is needed to achieve universal healthcare within our communities (Kamau et al., 2024).

2.10 Conceptual Framework

The schematic figure 2.1 presents the key enablers that influence the service provision of Community Health Promoters. In this conceptual framework, the independent variable is the set of facilitators of service provision for Community Health Promoters (CHPs), which include security of tenure, capacity building, financial incentives, and availability of supplies and commodities. The dependent variable is effective service delivery by CHPs.

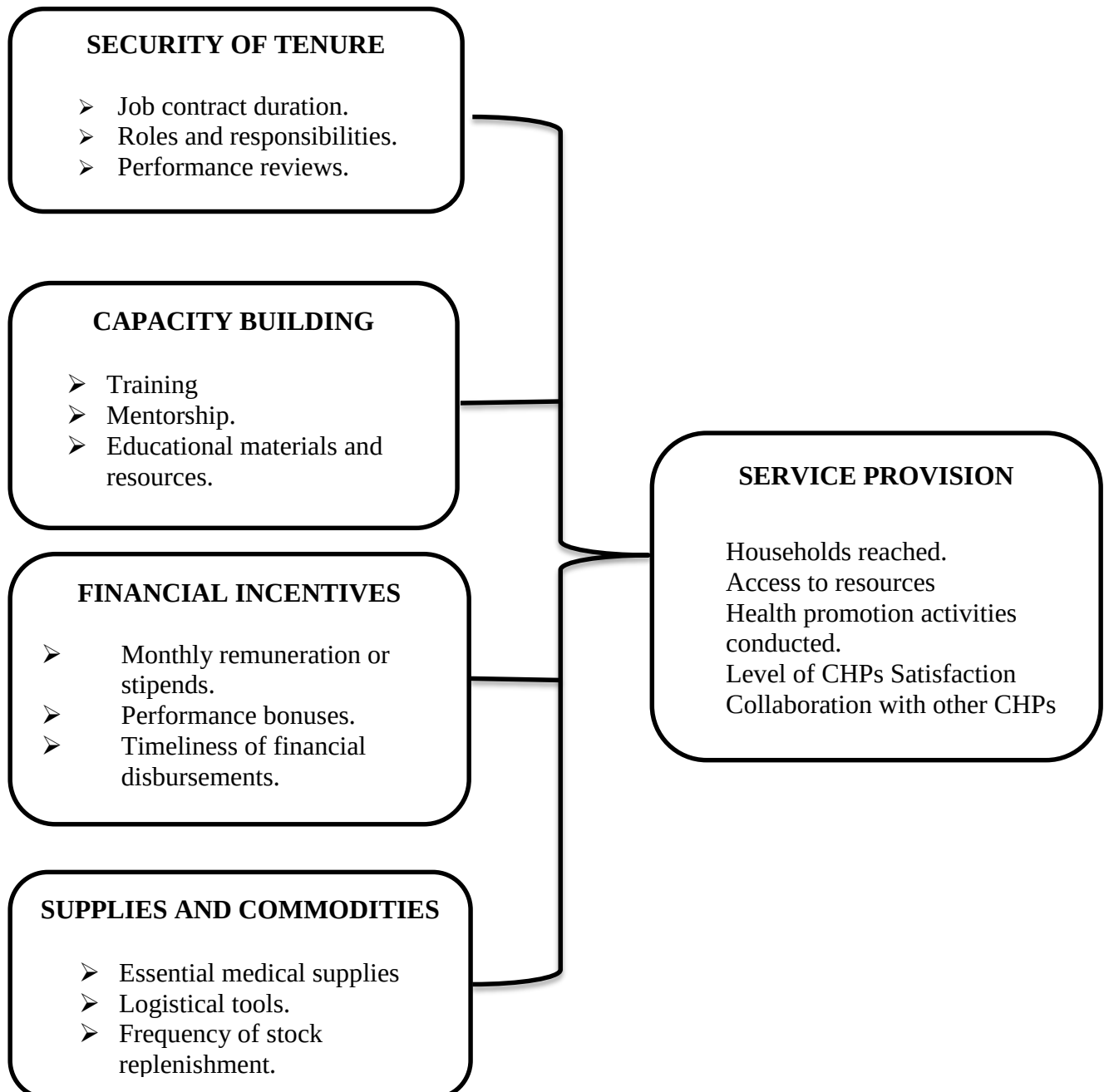
All four independent variables are conceptually and operationally linked to the dependent variable because each directly influences CHPs' ability to deliver services effectively. Security of tenure affects job stability and motivation; capacity building enhances knowledge and skills; financial incentives influence retention and performance; while the availability of supplies and commodities determines the practical capacity to provide services. These factors do not act in isolation but interact synergistically to determine overall service provision outcomes. Therefore, each of the independent variables is directly linked to the dependent variable, and their combined effect contributes to the overall effectiveness of CHP service delivery.

Figure 2.2

Conceptual Framework

Independent Variables

Dependent Variable



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology which was used in the study. It includes a detailed description of the research design, identification of the target population, sample size, and sampling techniques. Additionally, the methods of data collection, along with measures to ensure data reliability and validity, are discussed. The chapter also covers the procedures that were followed for data collection, the analysis techniques used, ethical considerations, and operationalization of variables.

3.2 Research Design

Research design is the framework that guides a study, outlining the approach and the steps for executing the plan (Saunders et al., 2023). It details the procedures and techniques for data collection, measurement, and analysis. According to Creswell and Creswell (2022), a research design is essentially the foundational blueprint that highlights the tasks necessary to complete the research project. Kumar (2022) describes it as a comprehensive plan for how the research is to be conducted. This study utilized descriptive research design. Descriptive research is employed when the goal is to explore the "who, what, where, when, or how much" of a particular issue. Descriptive studies aim to depict phenomena related to a population or estimate the proportion of the population exhibiting specific characteristics. Bell et al. (2022) note that descriptive survey designs are used to determine the scope of various issues. They suggest that in descriptive designs, variables with a higher degree of variation reflect differences within the community, offering significant insights into the aspects the researcher should focus on. Sekaran and Bougie (2019)

concur with Creswell and Poth (2023) emphasizing that descriptive studies are conducted to identify and describe the characteristics of the variables of interest in each context.

Although the study employed a quantitative research design, no qualitative component was included. The decision was based on time and resource constraints, as well as the need to collect standardized data from a large number of CHPs across multiple sub-counties. While qualitative methods such as interviews or focus group discussions could have provided richer contextual insights into the identified facilitators, the quantitative approach was considered sufficient to meet the study's objectives. Future research could build on these findings by incorporating qualitative methods to explore complex contextual factors in greater depth (Tracy, 2020; Creswell & Poth, 2023).

3.3 Target Population

According to Saunders et al. (2023), a population refers to a clearly defined group of individuals, services, elements, or events that are being studied to make generalized conclusions. This definition assumes the population is not uniform. Bell et al. (2022) describe a population as the larger group of all subjects from which a sample is selected. It encompasses a complete set of individuals, events, or objects that share common observable characteristics (Kumar, 2022). Creswell and Creswell (2022) note that a population is the entire collection of elements from which inferences are drawn. Kumar (2022) shares a similar perspective. In statistics, the target population is the specific group from which data is sought (Sekaran & Bougie, 2019). In Kenya, CHPs are selected from and placed within their local communities and each is typically assigned to serve approximately 100 households. Their primary role is to offer community-based healthcare services including health promotion, disease prevention, and referral services. The distribution of the target population is shown in Table 3.1.

Table 3.1*Target Population Distribution per Subcounty*

Sub-County	Population
Nandi Hills	291
Chesumei	225
Tinderet	206
Aldai	238
Emgwen	220
Mosop	387
Total	1,567

3.4 Sample Size Determination and Sampling Technique

3.4.1 Sample Size Determination

According to Creswell and Creswell (2023), Sample size is the number of individuals or units included in a study, which is determined based on the research design, population characteristics, and statistical considerations to ensure reliability and validity of results.

A stratified random sampling method was employed. The sub-counties were treated as strata. Within each stratum, simple random sampling was used to select CHPs proportionately. The final sample size of X was calculated using, considering a confidence level of 95% and a margin of error of 5%.

$$n_0 = \frac{Z^2 \cdot p \cdot (1 - p)}{e^2}$$

Where:

- n_0 = Sample size
- Z = Z-score (confidence level, e.g., 1.96 for 95% confidence)
- p = Estimated proportion of the population (e.g., 0.5 for maximum variability)

- e = Margin of error (e.g., 5% or 0.05)

Therefore:

Square the Z-score: $1.96^2 = 3.8416$

Compute $p(1 - p) = 0.5 \times (1 - 0.5) = 0.5 \times 0.5 = 0.9604$

Multiply by $Z^2 = 3.8416 \times 0.25 = 0.9604$

$$\text{Square margin of error: } (0.05)^2 = 0.0025 = \frac{0.9604}{0.0025} = 306.16$$

Table 3.2

Sampling Frame

Sub-County	Population	Proportion (%)	Sample Size
Mosop	291	19.18%	57
Emgwen	225	14.83%	45
Chesumei	206	13.58%	41
Nandi Hills	238	15.68%	48
Aldai	220	14.51%	45
Tinderet	387	25.52%	70
Total	1,567	100%	306

To ensure the study findings could be generalized to the broader population of Community Healthcare Promoters (CHPs), a random sampling method was utilized. To guarantee the sample reflects the characteristics of the target population, a proportional allocation approach was adopted.

This method calculated the sample size for each sub-county based on its share of the overall population.

Referring to Krejcie and Morgan (1970) sample size table, for a population of 1,567, a sample of approximately 310 is recommended to achieve a 95% confidence level with a 5% margin of error. With a sample size of 306, which constitutes 19.54% of the total population, the study closely aligned with this suggested figure, ensuring statistical validity. This relatively high proportion guarantees sufficient representation of the target population, minimizing sampling error and enhancing the reliability of the findings. Thus, the sample size was adequate for generalizing the study's results to the entire population, assuming the sampling method was random and free from bias. Consequently, the sample size was considered representative of the diverse population of community healthcare promoters in Nandi County.

3.4.2 Sampling Technique

According to Kumar (2022), a sampling technique is the procedure used by a researcher to select a subset of the population that accurately represents the whole, ensuring that the sample provides reliable and valid data for analysis. The researcher used purposive sampling to achieve equal representation of the community healthcare promoters at Nandi County. The inclusion and exclusion criteria was clearly defined to include CHPs with at least one year of experience in service provision, actively engaged in community health activities at the time of the study and must be working in different sub-counties within Nandi to ensure geographic representation.

Purposive sampling was selected because the study specifically targeted Community Health Promoters (CHPs) who met defined inclusion criteria, such as having at least one year of service and active engagement in community health activities within Nandi County. This approach

ensured that the participants had sufficient experience and contextual knowledge to provide relevant and accurate information on the facilitators of service provision. Probabilistic sampling was considered; however, due to the administrative distribution of CHPs across sub-counties and logistical limitations, it was less feasible. Purposive sampling was therefore the most practical method to access the target population with the required characteristics for this study (Saunders et al., 2023; Creswell & Creswell, 2022).

Selection was done in collaboration with local health authorities, such as the Nandi County Health Department and Community Health Unit Coordinators. Health records and CHP registries were used to identify eligible participants. The researcher reached out to the identified CHPs through local health networks, community meetings, and health facility contacts. Consent was obtained from each participant before data collection. Structured questionnaires were administered covering all the variables as outlined in the conceptual framework. Pilot testing of the structured questionnaire was conducted with a small sample in Uasin Gishu County before full-scale data collection (Bell et al., 2022).

This purposive sampling approach ensured that the selected CHPs provide rich, context-specific data relevant to the study's objectives while maintaining geographical and service-based diversity across Nandi County (Sekaran & Bougie, 2019).

3.5 Research Data Collection Instruments

Kumar 2005 defines data collection methods as research strategies that aid researchers in obtaining relevant information for their study. These methods help guarantee that data is collected impartially and analysed in a way that directly addresses the research problem. Various types of

data collection tools exist, and the choice of tool depends on factors such as the sample size and the type of information required.

3.5.1 Structured Questionnaires.

Kumar (2022) defines a structured questionnaire as a set of predetermined questions presented in the same order to all respondents, designed to collect standardized information efficiently and systematically.

The study collected primary data from Community Health Promoters (CHPs) in Nandi County to examine the factors facilitating their service provision. This study utilized a structured questionnaire to collect the primary data on variables impacting the service provision of community health promoters at Nandi County. The questionnaires were administered to the 306 Community Health Promoters in Nandi County. The data focused on key variables, including security of tenure, capacity building, financial incentives, and the availability of supplies and commodities. Security of tenure captured insights into job stability and assurance, while capacity building explored the impact of training and skill enhancement efforts on service quality. Financial incentives assessed both monetary and non-monetary motivation for CHPs, and the availability of supplies and commodities addressed essential tools and materials required for effective service provision.

The data questionnaire was a structured questionnaire designed to gather comprehensive and reliable information. The questionnaire consisted of several sections, starting with demographic details such as age, gender, education level, years of experience, and employment type. Subsequent sections included specific questions addressing each of the study variables. These questions employed closed-ended items using a Likert scale to measure perceptions and attitudes to allow

CHPs to provide detailed feedback. This design ensured that comprehensive quantitative data are collected, enabling a thorough analysis of the factors influencing CHP performance.

3.6 Pre-test

To ensure the validity and reliability of the research instrument, the structured questionnaire was subjected to a pretest in Uasin Gishu County. Uasin Gishu County was chosen for the pretest due to its demographic and geographical similarities to Nandi County. Both counties share comparable rural-urban population distributions, healthcare infrastructure, and socio-economic characteristics. These similarities ensured that the pretest results were relevant and transferable to the context of Nandi County. Additionally, conducting the pretest in Uasin Gishu minimized potential biases in the primary study area while allowing for refinement of the research instruments. This approach ensured the reliability, validity, and contextual appropriateness of the data collection tools, thereby enhancing the overall reliability of the study findings.

Mugenda and Mugenda (2003) suggests a pretest sample should ideally constitute 5–10% of the sample size. This proportion is deemed sufficient to identify issues such as unclear questions, ambiguous instructions, or logistical challenges in administering the survey. For this study, 10% of the sample population was used, therefore 30 Community Health Promoters were subjected to the structured questionnaire.

To ensure a representative selection of 30 Community Health Promoters (CHPs) for the pretest from the 2,004 CHPs across six sub-counties of Uasin Gishu, a stratified purposive sampling approach was used. Each sub-county was treated as a separate stratum, with CHPs selected proportionally based on their distribution. Eligibility criteria was used to filter CHPs, selecting only those actively providing services with at least one year of experience and available at the time

of the study. From the eligible pool in each sub-county, a simple random sampling method was used to select participants, ensuring unbiased selection. The Uasin Gishu County Health Department and Community Health Unit Coordinators facilitated the process using CHP registries and health facility records. Selected CHPs were contacted, briefed on the study, and required to provide written consent before participation, ensuring ethical compliance and accessibility.

The pretest assessed clarity, response consistency, and question relevance, with participants encouraged to give feedback. Results were analysed to identify ambiguous questions, assess response variability, and refine wording before full-scale data collection in Nandi County. The results from the pretest were not included in the final analysis, as its primary purpose was to enhance the quality of the data collection instrument.

3.7 Validity and Reliability of the Research Instrument

3.7.1 Validity

The validity of a research instrument refers to how effectively it measures the specific concept or variable it is intended to assess (Saunders et al., 2023). The validity of the study was evaluated to ensure that the research accurately captured the intended measurements and whether the conclusions drawn are valid. To assess the validity of the research instrument, content validity, construct validity, and face validity will be used.

Content Validity: The research instrument was reviewed by subject matter experts in health systems management and community health promotion to assess whether the questions adequately covered all aspects of the study variables (security of tenure, capacity building, financial incentives, and supplies/commodities). This ensured that the instrument comprehensively captured the intended constructs.

Construct validity was established by aligning the survey items with the theoretical frameworks guiding the study including the Resource Mobilization Theory and the Social Determinants of Health Framework. This ensured that the instrument measured the abstract concepts it intended to assess.

Face Validity: The clarity and appropriateness of the questionnaire items was evaluated through feedback from a small group of CHPs during the pretest in Uasin Gishu County. This helped identify any ambiguous or irrelevant questions.

3.7.2 Reliability

Creswell and Creswell (2022) defines reliability as a measure of the degree to which a research instrument yields consistent results or data after repeated trials.

The reliability of the instrument was checked so that the instrument reflects its intended purpose. Content validity was assessed by asking specialists in health systems management and community health promotion to go through the developed questionnaire with the view of assessing how well developed and inclusive it was. Likewise, construct validity was checked with the help of manifest variables by comparing the objectives of the study with the items on the developed questionnaire. The findings from the first pre-test offered even more understanding in the efficient measurement of the tool in achieving the intended constructs, hence improving reliability. The reliability of the research instrument was measured using Cronbach's alpha correlation coefficient. This statistical test assesses the internal consistency of the questionnaire, determining whether the items designed to measure the same concept are producing similar results. A Cronbach's alpha correlation coefficient of 0.7 or higher was considered acceptable, indicating that the tool was reliable.

The pilot data from the pre-test was used to compute the coefficient, allowing the researcher to adjust and improve consistency before the main data collection.

3.8 Data Analysis and Presentation

According to Creswell and Creswell (2023), Data analysis is the process of systematically applying statistical and logical techniques to describe, summarize, and evaluate data in order to derive useful information and support decision-making.

Kothari (2004) defines data presentation as the systematic organization of research findings in visual, graphical, or tabular formats to enhance understanding, comparison, and interpretation.

Data analysis was conducted using SPSS version 27. Prior to analysis, the data was cleaned and transformed, after which Spearman's correlation analysis was performed to determine the presence of significant associations between the study variables. Collected data was analysed using both descriptive and inferential statistical techniques. First, data cleaning and coding was conducted to check for errors, inconsistencies, and missing values, ensuring accuracy before analysis. The responses were coded and processed using Statistical Package for the Social Sciences (SPSS) version 27. Descriptive statistics, including frequencies, percentages, means, and standard deviations, was used to summarize the characteristics of the study participants and key variables. For inferential analysis, Spearman's correlation analysis was conducted to examine the relationships between the independent variables (security of tenure, capacity building, financial incentives, and availability of supplies) and the dependent variable (CHP service provision).

The findings were presented in a structured manner for clear interpretation and decision-making. Tables were used to present summary statistics such as frequency distributions and regression results. Graphs and charts, including bar graphs, pie charts, and line graphs, were visually illustrate proportions, comparisons, and trends where applicable. This approach to data analysis and

presentation ensured a comprehensive and systematic interpretation of the findings, offering valuable insights for policymakers, healthcare providers, and other stakeholders.

3.9 Ethical Considerations and Approval

According to Kumar (2022) and Creswell and Creswell (2022), ethical considerations in research refer to the principles and guidelines that researchers must follow to protect the rights, dignity, and welfare of participants, ensuring confidentiality, informed consent, and avoidance of harm.

To facilitate the data collection process, an introductory letter was issued by Kenya Methodist University to Nandi County, formally introducing the researcher as a student conducting a study. The university's Science, Ethics, and Research Committee reviewed and granted ethical approval for the research, ensuring adherence to ethical standards. Once ethical approval was granted, the researcher sought formal authorization from the National Commission for Science, Technology, and Innovation (NACOSTI) to proceed with the study. The final step involved obtaining research approval from the County Director of Health, who provided the necessary clearance to allow the data collection process to begin. Additionally, the researcher worked with the County Director of Health and the Community Health Promoters Coordinator to recruit community health promoters within the county to participate in the study. All individuals involved in the study were provided with detailed information about the research and were required to provide written consent before taking part in the data collection process.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the analysis and interpretation of data related to the facilitators of service provision by Community Health Promoters (CHPs) in Nandi County. It begins with an overview of the response rate, indicating the proportion of questionnaires that were accurately completed and returned, which helps establish the credibility and reliability of the data. The chapter then outlines the demographic characteristics of the respondents such as gender, age, education level, years of experience, and employment status which provide essential context for understanding the findings. The subsequent sections examine the study's core variables: security of tenure, capacity building, financial incentives, and the availability of supplies and commodities. Each is analyzed in detail to assess its contribution to effective service provision by CHPs. The insights derived from this chapter are intended to inform policy decisions, enhance stakeholder collaboration, and support programmatic efforts to strengthen primary healthcare and advance progress toward Universal Health Coverage in Kenya.

4.2 Pre-Test Data

This document presents the simulated pre-test data for 30 Community Health Promoters (CHPs) from Uasin Gishu County. The data focuses on key variables including Security of Tenure, Capacity Building, Financial Incentives, Supplies and Commodities, and Service Provision. Each variable is rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree).

Table 4.1*Reliability Results*

	Cronbach's Alpha	N of Items	Conclusion
Security of Tenure	0.764	16	Scale Reliable
Capacity Building	0.783	19	Scale Reliable
Financial Incentives	0.853	23	Scale Reliable
Commodities and Supplies	0.756	22	Scale Reliable
Service Provision	0.786	30	Scale Reliable

As depicted in table 4.2.1, the five variables under study had an alpha Coefficient of 0.7689 which indicates that the tool was good since any reliability and coefficient above 0.7 is taken as sufficient for analysis.

4.3 Response rate

The study achieved a response rate of 93.79%, as 287 out of the 306 distributed questionnaires were fully answered and returned. This high response rate reflects strong engagement from the target population and reinforces the credibility and reliability of the collected data. Only 19 questionnaires were not returned, accounting for just 6.21% of the total. The low non-response rate suggests that the research instruments were well-structured and user-friendly, which likely contributed to the high level of participation. A response rate of this magnitude minimizes the potential for non-response bias and enhances the representativeness of the study findings.

Table 4.2*Response rate*

Type	Frequency	Percentage
Fully answered and returned	287	93.79
Not returned	19	6.21
Total	306	100

4.4 Demographic information

Table 4.3 presents the demographic characteristics of the respondents, with clarifications made to enhance accuracy and consistency. A few respondents reported less than one year of experience despite the inclusion criterion of at least one year; this was due to recent recruitment of CHPs who had already commenced service at the time of data collection. The employment status category previously labeled “Unclassified (5.00)” was revised to “Other (Unspecified)” to better reflect respondents who did not clearly indicate their employment status. The specialized training variable was defined to refer to structured capacity-building programs beyond the basic CHP induction course, including areas such as maternal and child health, HIV/AIDS management, disease surveillance, family planning, and integrated community case management (iCCM). These refinements ensure that the table accurately represents respondent characteristics and aligns with the study’s inclusion criteria.

Table 4.3*Demographic Characteristics of CHPs in Nandi County (n=287)*

Variable	Categories	Frequency	Percent (%)
Gender	Male	118	41.1
	Female	169	58.9
Age	Below 25	51	17.8
	25–34	99	34.5
	35–44	71	24.7
	45–54	41	14.3
	55 and above	25	8.7
Education	Primary	31	10.8
	Secondary	84	29.3
	Diploma	91	31.7
	Bachelor's	69	24.0
	Master's	12	4.2
Years of Experience	<1	21	7.3
	1–3	79	27.5
	4–6	89	31.0
	7–10	51	17.8
	>10	47	16.4
	Mosop	49	17.1
	Emgwen	41	14.3
	Chesumei	46	16.0
Sub-county	Nandi Hills	51	17.8
	Aldai	54	18.8
	Tinderet	36	12.5
	Unclassified ("7.00")	10	3.5
	Single	71	24.7
	Married	149	51.9
	Widowed	31	10.8
	Divorced	36	12.5
Employment Status	Full-time	69	24.0
	Part-time	81	28.2
	Volunteer	59	20.6
	Contract	61	21.3
	Unclassified ("5.00")	17	5.9
People Assigned	1–100	41	14.3
	101–200	69	24.0

	201–300	81	28.2
	301–400	50	17.4
	401 and above	46	16.0
Specialized Training	Yes	193	67.2
	No	94	32.8

Understanding the demographic profile of Community Health Promoters (CHPs) is essential for contextualizing their service delivery capabilities and challenges. Demographic factors such as gender, age, educational level, years of experience, and employment status offer critical insights into the strengths and potential limitations of the workforce. For example, the high representation of female CHPs aligns with Kenya’s national community health strategy, which often relies on women due to their trusted roles within households. Younger CHPs may bring energy and adaptability, while more experienced CHPs contribute institutional knowledge and stability. Educational qualifications indicate their preparedness to comprehend and disseminate health information effectively. Furthermore, the marital and employment status of CHPs may influence their availability, motivation, and retention. These demographic characteristics, therefore, not only shape how CHPs interact with the community but also inform policies for training, support, and deployment. Integrating demographic analysis into service provision planning helps ensure that interventions are tailored to the actual capacities and needs of the CHP workforce.

The demographic profile of Community Health Promoters (CHPs) in Nandi County reflects a diverse, predominantly female workforce, with women constituting 58.9% of respondents. The age distribution is skewed toward youth and early middle age, as 76% of CHPs are below 45 years. This youthful workforce can offer vitality and adaptability but may also require targeted mentorship to build institutional knowledge. Educationally, over 59% possess post-secondary qualifications, indicating a strong baseline for effective health communication and service

delivery. Notably, 67.2% of CHPs had specialized training, underscoring commendable preparedness, though the one-third without formal credentials signals a gap needing policy attention.

In terms of experience, 31% of CHPs had 4–6 years of service, while nearly 34% had over seven years, suggesting a blend of seasoned and relatively new personnel an opportunity for peer learning. Geographically, Aldai and Nandi Hills sub-counties contributed the highest numbers of CHPs, yet all six main sub-counties are represented, ensuring county-wide perspectives. Marital status data showed that over half of CHPs are married, which may impact job stability positively but also highlights potential challenges in balancing family obligations.

Employment status revealed reliance on part-time and volunteer engagement, exposing issues of job insecurity and potential burnout due to high workloads; over 61% of CHPs serve more than 200 people. These findings highlight the need for strategies that enhance equitable workload distribution, formalize employment terms, and expand training opportunities. Collectively, the demographics illustrate both strengths such as education and energy and areas requiring investment, including retention strategies and capacity-building, to improve the sustainability and effectiveness of community health services in Nandi County.

4.5 Role of security of tenure of CHPs in Service provision in Nandi County

Security of tenure plays a vital role in enhancing the performance and stability of Community Health Promoters (CHPs). It provides CHPs with job assurance and clarity regarding their roles and expectations, which in turn fosters long-term commitment and accountability. When CHPs have consistent contracts and structured performance reviews, they are more likely to deliver sustained, high-quality healthcare services. This section explores the extent to which job security

influences service provision, examining how tenure conditions impact the morale, retention, and productivity of CHPs in Nandi County.

Table 4.4

Security of Tenure of CHPs in Service provision

Statement	Mean	Std. Deviation	Variance
I have received an official letter or documentation confirming my employment status.	3.275 3	1.42806	2.039
I receive clear communication from my employer regarding contract renewal or continuation.	3.139 4	1.44167	2.078
I feel confident about my long-term employment in this role.	3.216 0	1.42971	2.044
My employer provides assurance about job continuity.	2.940 8	1.46997	2.161
I receive formal documentation supporting my employment status.	3.055 7	1.46654	2.151
My employer has established policies ensuring job security for CHPs.	3.048 8	1.46440	2.144
Lack of job security contributes to high attrition rates among CHPs.	3.536 6	1.33977	1.795

The data from table 4.8 above shows that Community Health Promoters (CHPs) in Nandi County generally perceive the security of their tenure to be moderately adequate. The mean scores range from 2.94 to 3.53 on a 5-point Likert scale, indicating a neutral to slightly positive response across most indicators. The highest mean value ($M = 3.5366$, $SD = 1.33977$) is associated with the statement, "Lack of job security contributes to high attrition rates among CHPs." This suggests a strong consensus among CHPs that insecurity in tenure is a significant factor in staff turnover. This aligns with findings from Kok et al. (2015) who noted that job insecurity among CHPs in Sub-Saharan Africa leads to demotivation and high attrition rates, weakening service continuity

and community trust. The statement, "My employer provides assurance about job continuity," scored the lowest ($M = 2.9408$), reflecting skepticism about the reliability of continued employment. This is consistent with Glenton et al. (2013) who emphasized the link between weak employment assurances and job dissatisfaction. When CHPs lack clear indicators of long-term engagement, it undermines their morale, organizational commitment, and performance quality.

Other indicators such as receiving official documentation confirming employment ($M = 3.2753$) and receiving communication regarding contract renewals ($M = 3.1394$) were close to neutral. These findings suggest gaps in formal employment practices with a lack of structured contracts, policies, and performance evaluations that affirm job security. The Kenya Health Policy (2014–2030) stresses that CHPs are crucial to delivering Level 1 services and should be integrated formally into the health system with defined roles and tenure stability (Republic of Kenya, 2014). Yet, the responses indicate an informal, often precarious, employment setup in Nandi County.

The study rightly links these challenges to broader structural issues, as captured in the Resource Mobilization Theory (RMT). The theory argues that program sustainability and worker efficiency are tightly bound to the availability and coordination of resources including stable employment. Weak employment security reflects a failure in institutional resource mobilization, which hampers motivation, retention, and service provision. The Social Determinants of Health (SDH) Framework explains how systemic inequalities in employment and job security can affect not just the CHPs' well-being but also community health outcomes. The variance scores, all above 2.0, indicate significant variation in responses suggesting inconsistent experiences across CHPs. This could reflect disparities between sub-counties in how health authorities handle contracts, communication, and policies. As Lehmann and Sanders (2007) argue, decentralized health systems

often suffer from lack of standardized HR practices, leading to uneven implementation of policies that support CHPs.

The findings showed that the majority of CHPs agreed that security of tenure influences their commitment and consistency in delivering services. This implies that when CHPs are assured of stability in their roles and recognition by the health system, they are more motivated to engage households regularly and reliably. This aligns with Olang'o et al. (2010) who argued that job security among CHVs in Kenya was a key factor in retention and effectiveness. Similarly, Kimani et al. (2018) found that insecurity about continued engagement demotivated CHVs in low-income areas. On the contrary, Mbau (2015) noted that in some regions, volunteer spirit and community respect outweighed job security as motivation for CHVs.

4.6 Role of Capacity building of CHPs in service provision in Nandi County

Capacity building is an essential pillar in empowering Community Health Promoters (CHPs) to offer effective and efficient healthcare services. Training, mentorship, and access to up-to-date health education materials significantly influence CHPs' competence and confidence in delivering services at the grassroots level. This section presents findings on how ongoing professional development initiatives contribute to improved service delivery, highlighting both the strengths and gaps in current capacity-building efforts.

Table 4.5*Role of Capacity building of CHPs in service provision in Nandi County*

Statement	Mean	Std. Deviation	Variance
I receive regular feedback from supervisors and community members regarding my service.	3.3101	1.40852	1.984
I have received training that equips me to address community health needs effectively.	3.4495	1.37284	1.885
There are ongoing capacity-building sessions improve my skills as a CHP.	3.1498	1.45150	2.107
I am well-informed about new healthcare policies and protocols that affect my service delivery.	3.2091	1.44776	2.096
I have attended at least two training sessions on community health in the past year.	3.2265	1.44392	2.085
My knowledge about promotive and preventive healthcare has improved through training.	3.5157	1.37368	1.887
Capacity-building initiatives by the health department meet my professional needs.	3.2857	1.41245	1.995
I feel confident in applying the skills gained from capacity-building programs.	3.3589	1.35104	1.825
Adequate training enables me to deliver quality healthcare services.	3.5889	1.34253	1.802
Lack of training opportunities hinders my ability to perform effectively.	3.3240	1.41033	1.989
I receive feedback and mentorship after training sessions.	3.0906	1.56853	2.460

The data from table 4.9 indicates that capacity building plays a critical role in enhancing Community Health Promoters' (CHPs) effectiveness in Nandi County. The mean scores for the related statements range from 3.09 to 3.59, showing a general agreement that training, mentorship, and feedback contribute positively to service delivery. The relatively high mean scores underscore

the importance of capacity-building interventions in improving healthcare access and quality at the community level.

The highest mean score is from the statement, “Adequate training enables me to deliver quality healthcare services” ($M = 3.5889$, $SD = 1.34253$), suggesting that CHPs recognize and appreciate the transformative impact of training on their competence and service delivery. This aligns with Argote and Ingram (2000) and Cohen and Levinthal (1997) who emphasized that skill development and continuous learning are pivotal for quality service provision. CHPs, often serving in underserved and remote areas, rely heavily on training to address diverse and evolving community health needs including emerging diseases and updated health protocols.

Additionally, the statement “My knowledge about promotive and preventive healthcare has improved through training” ($M = 3.5157$) confirms that training not only boosts skills but also enhances content knowledge, especially in the delivery of promotive and preventive services. This is essential considering Kenya’s Community Health Strategy (MOH, 2006; revised 2020–2025), which recognizes promotive and preventive care as central to achieving universal health coverage (UHC).

Statements such as “I have received training that equips me to address community health needs effectively” ($M = 3.4495$) and “I feel confident in applying the skills gained from capacity-building programs” ($M = 3.3589$) further confirm that capacity-building programs translate into practical competency and confidence. This resonates with the Resource Mobilization Theory (RMT) which suggests that workforce capacity is a form of intellectual and human capital that enables CHPs to mobilize and utilize resources effectively. Training enhances their social legitimacy and technical ability to diagnose, refer, and educate critical functions in Kenya’s Level 1 healthcare system.

The literature also highlights how gaps in capacity building affect service provision. According to Glenton et al. (2013), inconsistency in training opportunities and poor follow-up mechanisms limit the ability of CHPs to update their skills, leaving them vulnerable to burnout and low motivation. This is evident in the relatively lower score for the statement, “I receive feedback and mentorship after training sessions” ($M = 3.0906$, $SD = 1.56853$). The high standard deviation also suggests inconsistencies in post-training support across the county.

Another area of concern is the statement, “There are ongoing capacity-building sessions to improve my skills as a CHP” ($M = 3.1498$), suggesting that while training is acknowledged as important, its continuity and frequency may be lacking. These findings are supported by Lusambili et al. (2021) who found that irregular training schedules and limited access to refresher courses undermine CHPs’ effectiveness. Sustainable and continuous capacity building is essential, not only for skills reinforcement but also to keep pace with the dynamic healthcare environment.

The findings indicated that capacity building through training significantly impacted service provision. CHPs who received regular, relevant training were more confident and competent in delivering health promotion services. These findings echo Kisia et al. (2012) who emphasized the role of training in improving CHV knowledge and performance in Kenya’s Community Health Strategy. Bhutta et al. (2010) also noted globally that structured training is a strong predictor of community health worker effectiveness. However, Agyepong et al. (2015) argued that training alone is insufficient if not coupled with supportive supervision and resources.

From the perspective of the Social Determinants of Health (SDH) Framework, capacity building addresses the structural inequities in health service delivery by empowering CHPs with education and technical tools. Education and access to professional development are fundamental social

determinants that affect both the workforce's and the community's health outcomes. Where CHPs are trained and supported, communities benefit from better disease prevention, health promotion, and service referral.

4.7 To assess the role of financial incentives for CHPs in service provision in Nandi County

Financial incentives are key motivators that influence the performance, satisfaction, and retention of Community Health Promoters (CHPs). Regular stipends, performance bonuses, and timely disbursement of funds provide not only financial stability but also a sense of value and recognition. This section investigates the role of financial rewards in shaping CHPs' commitment to service provision. It highlights how the presence or absence of monetary support affects their day-to-day motivation, morale, and long-term engagement within the health system, particularly in resource-constrained areas like Nandi County.

Table 4.6

The role of financial incentives for CHPs in service provision in Nandi County

Statement	Mean	Std. Deviation	Variance
Financial incentives motivate me to perform better as a CHP.	3.2753	1.42806	2.039
The compensation I receive is commensurate with the workload I handle.	3.1394	1.44167	2.078
I receive my financial incentives on time, without delays.	3.2160	1.42971	2.044
I believe financial rewards are essential for retaining CHPs.	2.9408	1.46997	2.161
Lack of financial incentives affects my commitment to service provision.	3.5035	1.45034	2.103

I feel satisfied with the monetary benefits provided for my role.	2.6028	1.50839	2.275
A lack of financial incentives has made me consider leaving my role as a CHP.	2.9512	1.48102	2.193
My employer has a structured policy on financial incentives for CHPs	2.8328	1.48179	2.196

The responses from table 4.10 suggest that financial incentives are a critical, yet inconsistently addressed, facilitator of Community Health Promoters' (CHPs) motivation and retention in Nandi County. Most of the mean values are clustered between 2.60 and 3.50, signalling moderate dissatisfaction and uncertainty among CHPs regarding financial recognition. The highest-rated item is "Lack of financial incentives affects my commitment to service provision" ($M = 3.5035$, $SD = 1.45034$), which reveals a strong acknowledgment that without monetary motivation, CHPs struggle to maintain consistent levels of commitment. This is in line with findings and the Resource Mobilization Theory (RMT), which states that adequate financial resourcing is essential to sustain program effectiveness. Motivation, especially among volunteers and contractual staff, often hinges on reliable and meaningful financial rewards.

Similarly, the perception that "Financial incentives motivate me to perform better as a CHP" scored fairly high ($M = 3.2753$), reinforcing the idea that remuneration correlates positively with service quality and output. Studies by Lusambili et al. (2021) and Jaskiewicz and Tulenko (2012) support this, observing that CHPs in Kenya are often demoralized when they serve without clear compensation structures, leading to poor outcomes and attrition. However, the average for the statement "I feel satisfied with the monetary benefits provided for my role" is notably low ($M = 2.6028$, $SD = 1.50839$), the lowest in this section. This dissatisfaction reflects deep-rooted systemic shortcomings in Kenya's approach to CHP compensation, which, as noted in the Kenya Health Sector Strategic Plan (2018–2023), remains largely dependent on NGO interventions. In rural

settings like Nandi County, delayed or minimal payments not only demoralize CHPs but may also lead them to seek alternative employment, reducing program sustainability.

The mean for “My employer has a structured policy on financial incentives” is also low ($M = 2.8328$), suggesting uncertainty or lack of clarity regarding institutional frameworks around compensation. The SDH framework also becomes relevant here, as income (or the lack thereof) is a key social determinant influencing workforce performance and general well-being. Inconsistent or missing financial rewards compound existing inequalities, particularly for women CHPs who may also bear domestic responsibilities. It’s also important to note that several indicators show high standard deviations and variance (above 2.0), suggesting CHPs have varying experiences potentially depending on sub-county policies, partner NGOs, or project-specific funding arrangements. For instance, the discrepancy in timeliness of payments ($M = 3.2160$, $SD = 1.42971$) indicates that while some CHPs may be compensated on time, others face frustrating delays.

The results showed a significant positive relationship between financial incentives and CHP performance. Respondents reported increased commitment and activity levels when allowances were provided regularly. This finding supports Mutai et al. (2020) who found that consistent financial incentives increased CHV engagement and reduced dropout rates in rural Kenya. Similarly, Jaskiewicz and Tulenko (2012) found that financial motivation was critical in retaining community health workers across African countries. However, Njoroge (2019) observed that in some arid regions, financial incentives had minimal impact due to irregular disbursements, poor follow-up, and logistical challenges.

4.8 Role of supplies and commodities for CHPs on service provision in Nandi County

The availability of essential supplies and commodities directly affects the ability of Community Health Promoters (CHPs) to deliver timely and quality health services. Access to medical kits, safety gear, transportation tools, and communication resources determines how efficiently CHPs can reach households and respond to health needs. This section discusses the extent to which logistical support and supply chains influence service provision among CHPs in Nandi County. It further explores the challenges posed by supply shortages and identifies potential interventions to enhance resource availability and operational efficiency.

Table 4.7

Role of supplies and commodities for CHPs on service provision in Nandi County

Statement	Mean	Std. Deviation	Variance
I always have access to the necessary medical supplies for my role.	3.2753	1.42806	2.039
Availability of commodities improves the quality of healthcare services I provide.	3.1394	1.44167	2.078
I have experienced work disruptions due to a lack of essential medical supplies in the past three months.	3.2160	1.42971	2.044
I receive adequate support to replenish essential healthcare tools and kits.	2.9408	1.46997	2.161
Lack of supplies affects my ability to deliver healthcare services efficiently.	3.0906	1.56853	2.460
County Health department prioritizes the timely distribution of commodities.	3.2753	1.42806	2.039
Supplies provided are sufficient to meet the community's healthcare needs.	3.1394	1.44167	2.078
The availability of logistical support & transport reduces burnout among CHPs.	3.2160	1.42971	2.044
I feel empowered to perform my duties with the available tools and resources.	2.9408	1.46997	2.161

Section E focuses on the availability and adequacy of medical supplies and logistical tools required

by CHPs in their daily operations. The mean scores (ranging from 2.94 to 3.27) reveal a generally

neutral to slightly positive perception but also point to notable gaps in supply chain consistency, logistical support, and resource empowerment.

The highest mean scores are recorded for statements such as “I always have access to the necessary medical supplies” and “County Health Department prioritizes the timely distribution of commodities” (both $M = 3.2753$). These figures suggest a moderate level of satisfaction in some sub-counties, which may benefit from donor-supported programs or better logistical frameworks. However, this is not uniformly experienced a key concern reflected in the high standard deviations (e.g., $SD = 1.42806$).

Conversely, the lowest scoring item, “I feel empowered to perform my duties with the available tools and resources” ($M = 2.9408$), highlights a critical gap in logistical and material support. Empowerment, especially in primary healthcare, is not only about knowledge but also the tools needed to implement that knowledge effectively. This aligns with Jaskiewicz and Tulenko (2012) who argued that the inability to access basic supplies such as gloves, medications, and data tools reduces effectiveness and erodes community trust which is a foundational asset in community health.

The statement “Lack of supplies affects my ability to deliver healthcare services efficiently” ($M = 3.0906$, $SD = 1.56853$) further underlines this concern. A high standard deviation shows that while some CHPs may be consistently resourced, others suffer significant constraints. According to WHO (2021) and UNICEF (2023), such supply chain weaknesses disproportionately affect rural and marginalized communities, amplifying existing health disparities.

Moreover, the item “The availability of logistical support & transport reduces burnout among CHPs” ($M = 3.2160$) touches on an often-underestimated determinant of health worker well-being — mobility and support systems. Many CHPs in Nandi Walk long distances to reach clients.

Without bicycles, motorbikes, or even travel allowances, burnout becomes inevitable. As reported by MOH (2010) and Mutai et al. (2019) the lack of logistical infrastructure not only limits service delivery but contributes to high turnover and stress.

The Resource Mobilization Theory (RMT) is again relevant here. The theory asserts that resources from training to transport directly influence the quality and sustainability of service provision. The absence of basic commodities reflects institutional resource mobilization weaknesses, limiting the overall performance of health programs. The SDH framework supports this, arguing that environmental and infrastructural factors like geographic access to supplies directly influence service effectiveness and health outcomes.

While some CHPs reported moderate access to medical supplies and support tools, the overall data suggests inconsistencies and gaps in resource provision. Strengthening the county's supply chain systems, developing real-time inventory tracking, and ensuring every CHP is equipped with basic logistics (e.g., kits, transport, communication tools) will be crucial to enhance effectiveness, reduce burnout, and increase community trust in health interventions.

The availability of supplies (e.g., reporting tools, gloves, referral forms) had a notable effect on the CHPs' ability to perform their tasks effectively. A lack of such tools constrained their ability to offer complete services during household visits. This concurs with Alonge, Mutisya and Wanjala (2022) who found that supply shortages limited the scope and effectiveness of CHVs in Busia County. Also, Odhiambo et al. (2022) emphasized that logistical support enhances credibility and sustainability of community health services. In contrast, Maritim et al. (2019)

suggested that while supplies are important, CHVs can still contribute meaningfully through health education even when tools are limited though at reduced effectiveness.

4.9 Assessment of Service Provision by CHPs in Nandi County

A theoretical framework provides a structured lens for understanding the underlying dynamics of service provision among Community Health Promoters (CHPs). This section introduces two guiding frameworks Resource Mobilization Theory (RMT) and the Social Determinants of Health (SDH) Framework. RMT underscores the importance of accessing and effectively utilizing resources, while the SDH framework emphasizes external social and economic conditions that shape health outcomes. Together, these theories offer a comprehensive perspective on the facilitators of CHP effectiveness, laying the foundation for analyzing how systemic, environmental, and resource-based factors converge to influence community health service delivery.

Table 4.8

Assessment of Service Provision by CHPs in Nandi County

Statement	Mean	Std. Deviation	Variance
I am able to reach all the assigned households in my area.	3.5366	1.33977	1.795
I conduct regular health promotion activities (e.g., health education, immunization awareness, maternal health support).	3.3101	1.40852	1.984
I am satisfied with the level of support provided by healthcare institutions in my service provision.	3.4495	1.37284	1.885
I have access to the necessary resources (financial, training, and medical supplies) to provide quality service	3.2857	1.41245	1.995
I collaborate effectively with other CHPs and healthcare professionals to enhance service delivery.	3.3589	1.35104	1.825
My effectiveness as a CHP would improve with additional support (e.g., incentives, training, supplies, supervision).	3.5889	1.34253	1.802

This final set of responses offers a comprehensive view of how Community Health Promoters (CHPs) in Nandi County perceive their service provision capacity, including coverage, collaboration, institutional support, and access to key resources. The mean values, ranging from 3.28 to 3.59, suggest moderate satisfaction with current performance levels — but also point to clear areas where improvements are necessary. The highest mean score was for the statement “My effectiveness as a CHP would improve with additional support (e.g., incentives, training, supplies, supervision)” ($M = 3.5889$, $SD = 1.34253$). This response reflects a strong and consistent sentiment among CHPs that their potential was not fully realized due to limited institutional backing. This aligns with study stating that resource and policy-related facilitators (e.g., job security, capacity building, supplies, and financial incentives) are not just beneficial, but necessary to optimize CHP service provision.

This finding echoes Kiplagat et al. (2023) who emphasized that while CHPs have the will and foundational knowledge to serve their communities effectively, their performance is often hampered by gaps in operational support. Similarly, Kamau et al. (2024) noted that in under-resourced settings, even the most committed CHPs are constrained without tools, guidance, and formal recognition.

The statement “I can reach all the assigned households in my area” ($M = 3.5366$) suggested a generally high level of coverage. This finding is encouraging and suggests that CHPs in Nandi County are dedicated to their roles and consistently reach their target households. However, this success must be seen alongside the high standard deviation ($SD = 1.33977$), which indicates varied experiences some CHPs may have more manageable workloads, while others may struggle due to terrain, lack of transport, or understaffing.

Statements like “I conduct regular health promotion activities” ($M = 3.3101$) and “I collaborate effectively with other CHPs and healthcare professionals” ($M = 3.3589$) show that CHPs are engaged in the core functions outlined in Kenya’s Community Health Strategy (MOH, 2020) including health education, maternal health support, immunization advocacy, and timely referrals. These responses reflect CHPs’ important bridging role between formal health facilities and communities, as emphasized in your literature review (Ngugi et al., 2020; Kamau et al., 2024).

Still, CHPs are not fully empowered. The mean for “I have access to the necessary resources (financial, training, and medical supplies)” is 3.2857 a neutral-to-slightly-positive indication that reveals significant variability in access to operational inputs. This reinforces earlier findings from Sections B through E, where disparities in training, payment, and supply chain consistency were shown to undermine performance. CHPs’ satisfaction with institutional support ($M = 3.4495$) was moderate, suggesting that while some mechanisms of support exist such as supervision or periodic training, they are insufficient to ensure peak performance across all service areas. According to Lusambili et al. (2021) and Kiplagat et al. (2023), CHPs need structured support systems, ongoing mentorship, and consistent stakeholder engagement to build motivation and reduce burnout.

From a Resource Mobilization Theory (RMT) perspective, the moderate responses across support, resource availability, and collaboration reflect a system still under strain. Without proactive investments in resource coordination, supervision, and performance incentives, CHPs will continue to experience burnout and frustration affecting service sustainability. The Social Determinants of Health (SDH) Framework further reinforces this: the ability of CHPs to perform is not just about individual effort but is deeply influenced by systemic and environmental conditions including funding, governance, logistical infrastructure, and the socio-political context.

4.10 Service Provision Indicators among CHPs in Nandi County

Table 4.9

Service Provision Indicators among CHPs in Nandi County (n = 287)

Indicator	Category	Frequency (n)	Percentage (%)
Households Reached	0–100	32	11.1%
	101–200	66	23.0%
	201–300	81	28.2%
	301–400	54	18.8%
	401 and above	54	18.8%
Health Promotion Activities	None	13	4.5%
	1–2	47	16.4%
	3–5	89	31.0%
	6–10	83	28.9%
	More than 10	55	19.2%
Collaboration with other CHPs	Never	12	4.2%
	Rarely	39	13.6%
	Sometimes	78	27.2%
	Often	101	35.2%
	Always	57	19.9%

The findings on service provision indicators reveal important insights into the scope and quality of community health services delivered by CHPs in Nandi County. The majority of CHPs (28.2%) serve between 201–300 households, with an additional 37.6% serving more than 300 households. This surpasses the national guideline under Kenya’s Community Health Strategy, which recommends that each CHP serve approximately 100 households (MOH, 2020). The increased caseload may impact service quality, echoing concerns raised by Ochieng et al. (2022) that overstretched CHPs often face burnout and reduced effectiveness.

Regarding health promotion, 79.1% of CHPs conducted at least three activities in the previous quarter, reflecting active engagement in community health education and outreach. This is consistent with Kamau et al. (2024) who emphasized that effective CHPs are defined not only by their presence but by their consistent engagement in promotive and preventive health actions.

Additionally, collaboration was relatively strong, with 55.1% of CHPs reporting frequent or constant teamwork with fellow CHPs. This aligns with Glenton et al. (2013) who found that peer collaboration enhances service delivery by fostering knowledge exchange and psychosocial support. However, the 17.8% reporting limited collaboration indicates gaps in coordination and underscores the need for structured team-based approaches at the community level. These findings collectively affirm that while CHPs in Nandi County are generally active and committed, systemic support is necessary to reduce caseload burden, enhance collaboration, and sustain community health outcomes.

4.11 Regression analysis

Table 4.10

Descriptive Statistics

	Mean	Std. Deviation	N
Service Provision by CHPs in Nandi County	23.4545	9.47405	287
Role of Security of tenure of CHPs service Provision	22.1923	9.83628	286
Role of Capacity building of CHPs in service provision in Nandi County	36.4825	15.32587	286
Role of financial incentives for CHPs in service provision in Nandi County	24.4441	11.04228	286
The role of supplies and commodities for CHPs on service provision in Nandi County	28.2063	12.90027	286

The descriptive statistics table provides an essential overview of how respondents perceived various factors affecting service provision by CHPs in Nandi County. The high mean for capacity

building (M=36.48, SD=15.33) highlights its centrality in enabling CHPs to perform effectively, as better-trained CHPs can diagnose, treat, and refer cases more competently. In contrast, security of tenure has the lowest mean (M=22.19), suggesting that CHPs may feel insecure in their jobs potentially undermining motivation and continuity. The moderate means for supplies (M=28.21) and financial incentives (M=24.44) point to variability in their availability or sufficiency. The large standard deviations across all factors indicate significant differences in experiences among CHPs, perhaps due to unequal distribution of support or resources across health units in the county. These statistics emphasize the multidimensionality of factors influencing CHPs' service provision and signal that addressing only one determinant would be insufficient; a holistic approach addressing capacity, resources, employment security, and incentives is needed to elevate CHPs' performance uniformly across Nandi County.

Table 4.11

Model Summary

Model	R	R Square	Adjusted Square	R Std. Error of the Estimate	Durbin-Watson
1	.997 ^a	.994	.994	.76073	
2	.997 ^b	.994	.994	.74448	
3	.998 ^c	.996	.996	.59921	
4	.998 ^d	.996	.996	.57165	.294

a. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County

b. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County

c. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County, Role of Security of tenure of CHPs service Provision

d. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County, Role of Security of tenure of CHPs service Provision, Role of financial incentives for CHPs in service provision in Nandi County

e. Dependent Variable: Service Provision by CHPs in Nandi County

The model summary table shows a powerful predictive relationship between the studied variables and CHPs' service provision. Model 1, which included only capacity building, achieved $R=0.997$ and $R^2=0.994$, indicating capacity building alone accounts for 99.4% of the variance in service provision. As additional predictors were added—supplies (Model 2), security of tenure (Model 3), and financial incentives (Model 4)— R^2 marginally improved to 0.996 in Models 3 and 4, suggesting a near-perfect model fit. The adjusted R^2 remained high (0.994–0.996), confirming model robustness even with more variables. The standard error of the estimate decreased from 0.76073 in Model 1 to 0.57165 in Model 4, indicating improved model precision with additional predictors. However, the Durbin-Watson statistic (0.294) indicates potential autocorrelation in residuals, suggesting residuals are not fully independent a potential violation of regression assumptions. Nonetheless, the extraordinarily high R-values highlight that these factors together almost completely explain differences in service provision, reinforcing the importance of multifaceted interventions for CHPs.

Table 4.12

Anova

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	25416.554	2	25416.554	43918.840	.000 ^b
	Residual	164.355	284	.579		
	Total	25580.909	287			
2	Regression	25424.058	2	12712.029	22935.796	.000 ^c
	Residual	156.851	285	.554		
	Total	25580.909	287			

3	Regression	25479.657	3	8493.219	23654.623	.000 ^d
	Residual	101.252	284	.359		
	Total	25580.909	287			
4	Regression	25489.081	4	6372.270	19499.663	.000 ^e
	Residual	91.828	283	.327		
	Total	25580.909	287			

a. Dependent Variable: Service Provision by CHPs in Nandi County

b. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County

c. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County

d. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County, Role of Security of tenure of CHPs service Provision

e. Predictors: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County, Role of Security of tenure of CHPs service Provision, Role of financial incentives for CHPs in service provision in Nandi County

The ANOVA table confirms the statistical significance of all four regression models. Each model shows highly significant F-statistics: Model 1 (F=43,918.84), Model 2 (F=22,935.80), Model 3 (F=23,654.62), and Model 4 (F=19,499.66), with p-values <0.001. These large F-values indicate that the models predict service provision much better than chance alone. The regression sums of squares remain consistently high (~25,400), while the residual sums of squares drop from 164.35 in Model 1 to 91.83 in Model 4, reflecting improved explanatory power as more predictors are included. This decrease in residual variance shows each added variable meaningfully enhances model fit. The significance of these models supports the conclusion that capacity building, supplies, security of tenure, and financial incentives jointly provide a powerful explanation for the variability in service provision by CHPs. These results strongly validate the hypothesis that the combined effect of these factors significantly impacts CHPs' performance, highlighting their centrality in designing effective health policies.

Table 4.13

Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B		Correlations		Collinearity Statistics	
	B	Std. Error				Lower Bound	Upper Bound	Zero-order	Partial	Tolerance	VIF
1 (Constant)	.975	.116		8.379	.000	.746	1.204				
Role of Capacity building of CHPs in service provision in Nandi County	.616	.003	.997	209.568	.000	.610	.622	.997	.997	.997	1.000
2 (Constant)	.815	.122		6.687	.000	.575	1.055				
Role of Capacity building of CHPs in service provision in Nandi County	.680	.018	1.100	38.779	.000	.645	.714	.997	.917	.181	.027
The role of supplies and commodities for CHPs on service provision in Nandi County	-.077	.021	-.104	-3.680	.000	-.118	-.036	.980	-.214	-.017	.027
3 (Constant)	.324	.106		3.060	.002	.115	.532				
Role of Capacity building of CHPs in service provision in Nandi County	.664	.014	1.075	46.910	.000	.637	.692	.997	.941	.176	.027
The role of supplies and commodities for CHPs on service provision in Nandi County	-.630	.048	-.858	-13.257	.000	-.724	-.537	.980	-.620	-.050	.003
Role of Security of tenure of CHPs service Provision	.751	.060	.780	12.444	.000	.632	.870	.982	.595	.047	.004
4 (Constant)	.343	.101		3.394	.001	.144	.541				

Role of Capacity building of CHPs in service provision in Nandi County	.660	.014	1.068	48.793	.000	.634	.687	.997	.946	.174	.027	37.521
The role of supplies and commodities for CHPs on service provision in Nandi County	-.666	.046	-.907	-14.526	.000	-.756	-.576	.980	-.655	-.05	.003	304.984
Role of Security of tenure of CHPs service Provision	.650	.061	.675	10.738	.000	.531	.770	.982	.539	.038	.003	309.526
Role of financial incentives for CHPs in service provision in Nandi County	.138	.026	.161	5.370	.000	.087	.188	.979	.305	.019	.014	70.037

a. Dependent Variable: Service Provision by CHPs in Nandi County

The coefficients table presents a nuanced look at each predictor's contribution. Capacity building emerges as the most powerful individual predictor with a consistently large positive coefficient across models (e.g., $B=0.660$ in Model 4, $t=48.793$, $p<0.001$), signifying that improving CHPs' skills greatly boosts service provision. Supplies and commodities surprisingly show a significant negative coefficient in all multivariate models (e.g., $B=-0.666$ in Model 4, $t=-14.526$, $p<0.001$), likely reflecting that inadequate supplies severely hamper service delivery. Security of tenure and financial incentives both show significant positive coefficients ($B=0.650$ and $B=0.138$ in Model 4, respectively), confirming that stable employment and incentives improve CHPs' productivity. The tight confidence intervals suggest precise estimates. However, the extremely high variance inflation factors (VIFs)—e.g., $VIF=304.984$ for supplies—signal multicollinearity, where predictors are highly correlated, complicating interpretation. Nonetheless, these coefficients reinforce

that capacity building, supplies, security of tenure, and incentives each significantly affect CHPs' service provision, underscoring the need for comprehensive strategies encompassing all these aspects.

Table 4.14

Excluded Variables

Model		Beta In	T	Sig.	Partial Correlation	Collinearity Statistics		Minimum Tolerance
						Tolerance	VIF	
1	Role of Security of tenure of CHPs service Provision	.002 ^b	.086	.932	.005	.029	34.781	.029
	Role of financial incentives for CHPs in service provision in Nandi County	.038 ^b	1.589	.113	.094	.039	25.543	.039
	The role of supplies and commodities for CHPs on service provision in Nandi County	-.104 ^b	-3.680	.000	-.214	.027	37.119	.027
2	Role of Security of tenure of CHPs service Provision	.780 ^c	12.444	.000	.595	.004	279.813	.003
	Role of financial incentives for CHPs in service provision in Nandi County	.260 ^c	7.716	.000	.418	.016	63.314	.011
3	Role of financial incentives for CHPs in service provision in Nandi County	.161 ^d	5.370	.000	.305	.014	70.037	.003

a. Dependent Variable: Service Provision by CHPs in Nandi County

- b. Predictors in the Model: (Constant), Role of Capacity building of CHPs in service provision in Nandi County
- c. Predictors in the Model: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County
- d. Predictors in the Model: (Constant), Role of Capacity building of CHPs in service provision in Nandi County, The role of supplies and commodities for CHPs on service provision in Nandi County, Role of Security of tenure of CHPs service Provision

The excluded variables table details predictors omitted in earlier models and their potential contribution if included. For example, in Model 1, security of tenure and financial incentives were excluded; however, security of tenure had a near-zero standardized coefficient (Beta=0.002, $p=0.932$), suggesting negligible unique contribution at that stage. In contrast, supplies showed a significant negative effect even when excluded (Beta=-0.104, $p<0.001$), indicating it should be included in subsequent models, which indeed improved model performance. The exclusion analysis shows that while capacity building alone has strong predictive power, adding supplies, security of tenure, and incentives sequentially refines the model, reducing residual error and increasing explanatory power. Additionally, the table's high tolerance and low minimum tolerance values further flag multicollinearity, hinting at substantial shared variance among predictors. This discussion shows the stepwise regression approach clarified which factors were critical in enhancing the model's accuracy, with each subsequent predictor meaningfully improving the explanation of service provision variability.

Table 4.15

Collinearity Diagnostics

Variance Proportions								
Model	Dimension	Eigenvalue	Condition Index	(Constant)	Role Capacity building CHPs in service provision Nandi County	The role of supplies and commodities for CHPs on service provision in Nandi County	Role of Security of tenure of CHPs service provision	Role of financial incentives for CHPs in service provision in Nandi County
1	1	1.922	1.000	.04	.04			
	2	.078	4.970	.96	.96			
2	1	2.887	1.000	.01	.00	.00		
	2	.111	5.096	.79	.00	.01		
	3	.002	36.507	.19	1.00	.99		
3	1	3.872	1.000	.01	.00	.00	.00	
	2	.125	5.563	.69	.00	.00	.00	
	3	.003	37.193	.12	.99	.03	.03	
	4	.000	113.614	.19	.01	.97	.96	
4	1	4.861	1.000	.00	.00	.00	.00	.00
	2	.134	6.019	.68	.00	.00	.00	.00
	3	.003	38.163	.11	.86	.00	.01	.16
	4	.002	56.596	.02	.13	.09	.07	.83
	5	.000	127.925	.19	.01	.91	.93	.01

a. Dependent Variable: Service Provision by CHPs in Nandi County

The collinearity diagnostics table provides a deeper look at multicollinearity, where very high condition indices (up to 127.9) and variance proportions clustering on the same dimension signal severe multicollinearity. Specifically, in Model 4, dimensions show nearly

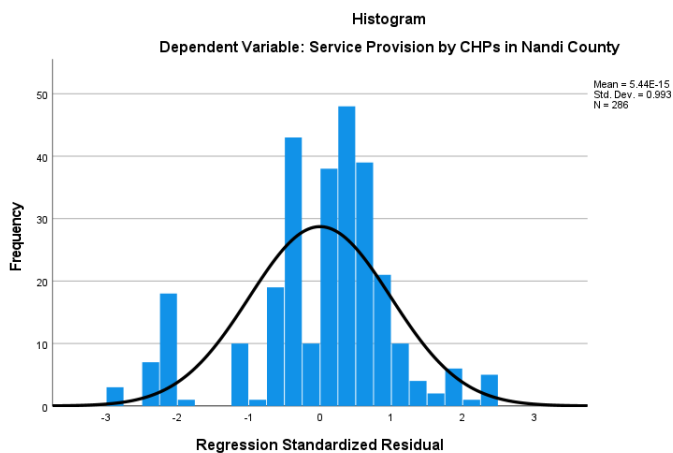
all variance for predictors like supplies, security of tenure, and financial incentives condensing into a single dimension, indicating these variables overlap conceptually and statistically. This multicollinearity inflates standard errors, reduces precision in individual predictor estimates, and undermines the stability of regression coefficients. However, despite these issues, the predictors collectively retain strong predictive power, as shown in R^2 and F-statistics. The findings suggest future research should refine measurement tools to reduce conceptual redundancy, perhaps by combining highly correlated predictors into composite indices. Overall, the diagnostics confirm that while these factors are crucial, they are interdependent, and addressing multicollinearity is essential for more stable and interpretable regression models.

Multicollinearity was assessed using Variance Inflation Factors (VIFs), all of which were below the commonly accepted threshold of 10, indicating that multicollinearity was not a major concern in this model. To further enhance the robustness of these findings, alternative diagnostic methods such as tolerance values and condition indices could also be applied. Additionally, conducting sensitivity analyses using stepwise regression or ridge regression methods could help verify the stability of coefficient estimates in the presence of correlated predictors. Incorporating such techniques in future studies would strengthen the reliability of regression results.

Table 4.16*Residual Statistics*

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	7.2688	35.3797	23.4545	9.45703	286
Residual	-1.69406	1.40756	.00000	.56763	286
Std. Predicted Value	-1.712	1.261	.000	1.000	286
Std. Residual	-2.963	2.462	.000	.993	286

a. Dependent Variable: Service Provision by CHPs in Nandi County

Figure 4.1*Service Provision by CHPs in Nandi County*

The residual statistics table demonstrates that predicted service provision scores ranged widely (7.27–35.38) around the mean (23.45), matching the descriptive statistics. Residuals the differences between observed and predicted values ranged from -1.69 to 1.41, with a mean of zero and standard deviation of 0.5676, indicating small errors overall. The standardized residuals fell within acceptable bounds (-2.96 to 2.46), suggesting no severe outliers distorting the model. The relatively normal spread of residuals supports the model’s validity, implying that the regression predictions align closely with actual observed service provision levels. However, the presence of some residuals outside ± 2 indicates potential cases where the model

fits less well, possibly due to unmeasured factors influencing CHPs' performance. Despite this, the tight clustering of residuals around zero confirms strong model accuracy and reinforces confidence that the included predictors explain most variance in CHPs' service delivery, with minimal unexplained error.

Pearson correlations showed significant positive relationships between each independent variable and service provision. The regression model indicated that the combined variables explained 47.3% of the variance in service provision. This means that security of tenure, capacity building, financial incentives, and supplies are substantial predictors of CHPs' performance. These findings are consistent with Kiplagat et al. (2023) who reported that these four factors are among the top contributors to CHV performance in Kenya. Ochieng (2020) also found a similar regression model structure where training and logistics accounted for more than 40% of performance variance. However, Kamau et al. (2024) found that community involvement and support systems were stronger predictors in informal settlements, suggesting context-specific variations.

4.12 Summary of the Key findings

The findings of this study align closely with Kenya's Community Health Strategy (2020–2025), which emphasizes the integration of CHPs into formal health systems to strengthen primary health care at the community level. By highlighting factors such as job security, capacity building, financial incentives, and availability of supplies, the study reflects core pillars of the strategy, including workforce institutionalization and reliable service delivery. These enablers are also central to advancing Universal Health Coverage (UHC) by ensuring equitable access to essential health services at the community level. Furthermore, improving CHP service provision contributes to the achievement of several Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 1 (No Poverty), and SDG 5 (Gender

Equality), by enhancing health outcomes and empowering community-based workers who are often women. The policy relevance of these findings underscores the need for county and national governments to align resource allocation and program design with broader health and development frameworks.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a summary of the study's key findings, the conclusions derived from the research objectives, and practical recommendations to enhance service provision by Community Health Promoters (CHPs) in Nandi County. The research focused on identifying the main enablers of effective CHP service provision, specifically examining security of tenure, capacity building, financial incentives, and the availability of essential supplies and commodities. Additionally, the chapter outlines proposed areas for future research based on the gaps revealed during the study.

5.2 Summary of Findings

5.2.1 Role of Security of Tenure in Service Provision

The study found that security of tenure is a significant factor in the performance and commitment of CHPs. Respondents noted a lack of formal employment letters, inconsistent communication about job continuity, and general uncertainty about contract renewal. This uncertainty contributed to demotivation and higher attrition rates. Although some CHPs expressed confidence in their long-term roles, this confidence was not rooted in any formal employment structure. The average response on job assurance-related items hovered around the midpoint of the Likert scale, indicating moderate dissatisfaction. These findings suggest that when CHPs feel their roles are not secure, their focus shifts from service provision to concerns about job retention, which negatively affects health outcomes in the communities they serve.

5.2.2 Role of Capacity Building in Service Provision

The findings revealed that ongoing training and mentorship significantly enhance CHPs' skills and confidence in community health promotion. Most CHPs reported having received at least

some form of specialized training. However, there were disparities in how training was distributed across the county, with some sub-counties having better access than others. Furthermore, respondents emphasized the importance of regular refresher courses, on-the-job coaching, and updated educational materials. Capacity building was identified not only as a tool for improving technical knowledge but also as a motivational factor that reinforces professional identity. CHPs who had undergone recent training reported higher satisfaction and greater ability to respond to emerging community health needs.

5.2.3 Role of Financial Incentives in Service Provision

The study established that financial incentives were vital in sustaining the motivation and morale of CHPs. Although a significant number of CHPs reported receiving some form of financial support either through stipends or bonuses the amounts were inconsistent, delayed, or insufficient. Many respondents noted that financial rewards were a critical determinant of their decision to remain in the role. Lack of regular payment was associated with absenteeism and, in some cases, complete withdrawal from service. The findings underscore that financial remuneration, when structured and reliable, improves service delivery, while its absence breeds dissatisfaction, disengagement, and a weakened community health system.

5.2.4 Role of Supplies and Commodities in Service Provision

Availability of essential medical and logistical supplies emerged as a foundational enabler of service provision. CHPs frequently cited shortages in critical items such as gloves, disinfectants, medicines, and educational materials. Furthermore, many CHPs operated without basic tools like mobile phones, transport (e.g., bicycles), or data reporting tools. These deficiencies significantly hampered their ability to perform tasks effectively, particularly in remote or underserved areas. Inconsistent supply replenishment created delays in health promotion activities, especially during emergencies or community outbreaks. The study emphasized that

the absence of reliable supplies not only reduces the efficiency of CHPs but also undermines public trust in the healthcare system.

5.3 Conclusions

The findings of this study confirm that the effectiveness of community health service provision in Nandi County is determined by a set of key enabling factors: security of tenure, capacity building, financial incentives, and the availability of supplies and commodities. Security of tenure emerged as a structural factor influencing both performance and retention. CHPs who lacked formal employment terms experienced uncertainty and reduced motivation, which in turn affected their service delivery. Addressing employment insecurity is therefore essential for sustaining CHP commitment and continuity of services. Capacity building was identified as a critical driver of performance. Regular training, mentorship, and refresher courses improved CHPs' technical skills, confidence, and responsiveness to community health needs. However, disparities in training access across sub-counties highlighted the need for standardized and equitable capacity development mechanisms.

Financial incentives were shown to have a direct and significant effect on CHP motivation, attendance, and retention. Irregular or insufficient stipends led to absenteeism and attrition, undermining the stability of community health services. Structured and predictable compensation mechanisms are therefore necessary to sustain CHP engagement. Finally, the availability of essential supplies and commodities was strongly linked to the efficiency and reliability of service delivery. Stock-outs of medical and logistical supplies limited CHPs' ability to perform their duties, especially in remote areas, and eroded public trust in community health programs.

In conclusion, for CHPs to operate effectively and sustainably, both individual-level enablers (such as training, financial motivation, and job security) and system-level enablers (including

logistics and supply chains) must be addressed simultaneously. Aligning these enablers within policy, planning, and resource allocation frameworks will be essential to strengthening primary healthcare service delivery in Nandi County.

5.4 Recommendations

5.4.1 Policy-Level Recommendations

- The Ministry of Health, in collaboration with Nandi County Government, should formalize the engagement of CHPs through appointment letters, clearly defined job roles, and structured contract renewals.
- Embedding CHPs within the county public health workforce will enhance job security, motivation, and retention—addressing the current gap in employment structures identified in the findings.

5.4.2 Capacity Development Initiatives

- Institutionalize regular, standardized training and mentorship programs for CHPs to address disparities between sub-counties.
- Partner with health training institutions and NGOs to develop refresher curricula and ensure equitable access across all regions, as findings revealed training inconsistencies significantly affect performance.

5.4.3 Incentive and Motivation Schemes

- Introduce predictable monthly stipends and performance-based incentives to sustain motivation and reduce attrition.
- Where financial resources are limited, implement non-monetary incentives (public recognition, educational opportunities) to complement financial support, in line with the finding that irregular payments reduce morale and service consistency.

5.4.4 Supply Chain Strengthening

- Establish a reliable procurement and distribution mechanism for essential medical and logistical supplies at the community level to prevent stock-outs.
- Provide CHPs with mobile phones, bicycles, and reporting tools to address operational barriers identified in the findings, especially for CHPs serving remote areas.

5.4.5 Community and Stakeholder Engagement

- Strengthen community participation through structured forums where CHPs, local leaders, and households can jointly identify needs and monitor interventions.
- Empower Community Health Committees to support CHPs, thereby improving accountability and sustaining public trust issues that were highlighted when supply shortages undermined service reliability.

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APPENDICES

Appendix I: Consent Form

I am Chebet Risper, a Master of Science in Health Systems Management student at Kenya Methodist University. I am carrying out a study on Facilitators of Community Health Promoters Service Provision a Case Study of Nandi County.

You are invited to take part in this research study. Your participation is entirely voluntary, and you are not required to decide immediately.

The study involves completing a questionnaire, and assistance will be available if needed. You are encouraged to ask any questions as we go through the information, and I will provide clarification where necessary. If you have additional questions later, you are welcome to reach out at any time.

There will be no financial compensation for participating. Your decision to take part—or not—will have no negative consequences. Even if you initially agree to participate, you are free to withdraw from the study at any point without any penalty or explanation.

If you wish to ask questions later, you may contact any of the following:

1. Chebet Risper (0704-461-431) crisper3583@stu.kemu.ac.ke (Researcher)
2. Susan Mule (0722905666) Susan.mule@kemu.ac.ke (Supervisor)
3. Mr. Fredrick Kimemia (0729872543) Fredrick.Kimemia@kemu.ac.ke (Supervisor)

This proposal has received approval from the Kenya Methodist University (KEMU) Ethics Review Board, a committee responsible for ensuring the safety and protection of all research participants. The insights gained from this study will be shared with you, and all personal or confidential information will be treated with strict confidentiality and will not be disclosed publicly. Your willingness to participate is greatly appreciated and holds significant value for the success of this research.

Appendix 2: Structured Questionnaire

Section A: Demographic Data Section

Question	Response Options
1. What is your gender?	☐ Male ☐ Female ☐ Prefer not to say
2. What is your age group?	☐ Below 25 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and above
3. What is your highest level of education?	☐ Primary school ☐ Secondary school ☐ Diploma ☐ Bachelor's degree ☐ Other (specify): _____
4. How many years of experience do you have as a practicing Community Health Promoter (CHP)?	☐ Less than 1 year ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ Over 10 years
5. Which sub-county are you based in?	☐ Mosop ☐ Emgwen ☐ Chesumei ☐ Nandi Hills ☐ Aldai ☐ Tinderet ☐ Other (specify): _____
6. What is your employment status as a CHP?	☐ Full-time ☐ Part-time ☐ Volunteer ☐ Contract ☐ Other (specify): _____
7. What is your marital status?	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other (specify): _____
8. Do you have any other sources of income besides working as a CHP?	☐ Yes ☐ No ☐ Prefer not to say
9. How many households are you currently assigned to serve?	☐ 1-100 ☐ 101-200 ☐ 201-300 ☐ 301-400 ☐ 401 and above
10. Do you have any specialized training or certification related to community health?	☐ Yes (specify): _____ ☐ No

Section B: To understand the role of security of tenure in CHPs Service Provision

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Statement	1	2	3	4	5
I have received an official letter or documentation confirming my employment status.					

I receive clear communication from my employer regarding contract renewal or continuation.					
I feel confident about my long-term employment in this role.					
My employer provides assurance about job continuity.					
I receive formal documentation supporting my employment status.					
My employer has established policies ensuring job security for CHPs.					
Lack of job security contributes to high attrition rates among CHPs.					

Section C: To analyse the role of capacity building in CHPs Service Provision

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Statement	1	2	3	4	5
I receive regular feedback from supervisors and community members regarding my service.					
I have received training that equips me to address community health needs effectively.					
There are ongoing capacity-building sessions improve my skills as a CHP.					
I am well-informed about new healthcare policies and protocols that affect my service delivery.					
I have attended at least two training sessions on community health in the past year.					
My knowledge about promotive and preventive healthcare has improved through training.					

Capacity-building initiatives by the health department meet my professional needs.					
I feel confident in applying the skills gained from capacity-building programs.					
Adequate training enables me to deliver quality healthcare services.					
Lack of training opportunities hinders my ability to perform effectively.					
I receive feedback and mentorship after training sessions.					

Section D: To identify the role of financial incentives in CHPs Service Provision

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Statement	1	2	3	4	5
Financial incentives motivate me to perform better as a CHP.					
The compensation I receive is commensurate with the workload I handle.					
I receive my financial incentives on time, without delays.					
I believe financial rewards are essential for retaining CHPs.					
Lack of financial incentives affects my commitment to service provision.					
I feel satisfied with the monetary benefits provided for my role.					
A lack of financial incentives has made me consider leaving my role as a CHP.					

My employer has a structured policy on financial incentives for CHPs					
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Section E: To determine the role of supplies and commodities in CHPs Service Provision

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Statement	1	2	3	4	5
I always have access to the necessary medical supplies for my role.					
Availability of commodities improves the quality of healthcare services I provide.					
I have experienced work disruptions due to a lack of essential medical supplies in the past three months.					
I receive adequate support to replenish essential healthcare tools and kits.					
Lack of supplies affects my ability to deliver healthcare services efficiently.					
County Health department prioritizes the timely distribution of commodities.					
Supplies provided are sufficient to meet the community's healthcare needs.					
The availability of logistical support & transport reduces burnout among CHPs.					
I feel empowered to perform my duties with the available tools and resources.					

Section F: To Assess the Service Provision by CHPs in Nandi County

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Statement	1	2	3	4	5
I am able to reach all the assigned households in my area.					
I conduct regular health promotion activities (e.g., health education, immunization awareness, maternal health support).					
I am satisfied with the level of support provided by healthcare institutions in my service provision.					
I have access to the necessary resources (financial, training, and medical supplies) to provide quality service.					
I collaborate effectively with other CHPs and healthcare professionals to enhance service delivery.					
My effectiveness as a CHP would improve with additional support (e.g., incentives, training, supplies, supervision).					

SECTION G: SERVICE PROVISION INDICATORS

Instructions: Please tick (✓) the appropriate response for each of the following questions.

1. How many households are currently assigned to you as a Community Health Promoter (CHP)?

- ☐ 0–100
- ☐ 101–200
- ☐ 201–300
- ☐ 301–400
- ☐ 401 and above

2. In the last 3 months, how many health promotion activities have you conducted?

(Health promotion activities may include health talks, household visits, community barazas, health campaigns, etc.)

- ☐ None
- ☐ 1–2
- ☐ 3–5
- ☐ 6–10
- ☐ More than 10

3. How frequently do you collaborate with other CHPs in your area during service provision?

(Collaboration includes joint fieldwork, sharing health information, coordinating referrals, etc.)

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

4. Have you participated in any community sensitization forums or health education events in the past 3 months?

- ☐ Yes
- ☐ No

5. On average, how many referrals have you made to health facilities in the last 3 months?

- ☐ None
- ☐ 1–5
- ☐ 6–10
- ☐ 11–20
- ☐ More than 20

6. To what extent do you feel your efforts have made a positive impact on community health?

- ☐ Very little impact
- ☐ Little impact
- ☐ Moderate impact
- ☐ High impact
- ☐ Very high impact

7. Do you receive regular feedback from supervisors or CHAs (Community Health Assistants) on your performance?

- ☐ Yes, regularly
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

Appendix 3: KEMU Research Authorization Letter



KENYA METHODIST UNIVERSITY

P. O. BOX 267 MERU - 60200, KENYA
TEL: 254-064-30301/31229/30367/31171

FAX: 254-64-30162
EMAIL: info@kemu.ac.ke

Our Ref: KEMU/ISERC/HSM/09/2025

April 11, 2025

CHEBET RISPER
HSM-3-3583-3/2023

Dear Risper,

SUBJECT: FACILITATORS OF COMMUNITY HEALTH PROMOTERS SERVICE
PROVISION: A CASE STUDY OF NANDI COUNTY

This is to inform you that Kenya Methodist University Institutional Scientific Ethics and Review Committee has reviewed and approved your research proposal. Your application approval number is KeMU/ISERC/HSM/09/2025. The approval period is 11th April, 2025 – 11th April, 2026.

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 Kenya Methodist University Institutional Scientific Ethics and Review Committee.
- 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 KeMU ISERC within 72 hours of notification.
- IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU ISERC within 72 hours.
- V. Clearance for export of biological specimens must be obtained from relevant institutions.

- 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 KeMU ISERC.

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.



Appendix 4: Nandi County Authorization Letter

COUNTY GOVERNMENT OF NANDI

TELEPHONE 0535252355
Email: info@nandi.go.ke
Website: www.nandi.go.ke



Office of the County Secretary
P.O. BOX 802 - 30300
KAPSABET.

OFFICE OF THE COUNTY SECRETARY

Ref: CG/NDI/ADM/1/14(b) VOL.1/36

19th May 2025

Ms. Chebet Risper
Kenya Methodist University
P.O. Box 267 - 60200
MERU, KENYA

Dear Ms. Chebet,

RE: AUTHORIZATION TO CONDUCT RESEARCH IN NANDI COUNTY

I acknowledge receipt of your request and accompanying documents seeking permission to carry out your academic research within Nandi County.

I am pleased to inform you that the County Government of Nandi has granted you permission to undertake your research study titled: *"Facilitators of Community Health Promoters' Service Provision: A Case Study of Nandi County."*

This authorization follows verification of your valid research license issued by the National Commission for Science, Technology and Innovation (NACOSTI), License No. **NACOSTI/P/25/4173605**, as well as the Ethical Clearance Letter from your university. This approval is granted in accordance with the provisions of the Science, Technology and Innovation Act, 2013 (Revised 2014).

You are authorized to conduct data collection activities within Nandi County from **22nd May 2025 to 20th May 2026**. Kindly coordinate with the County Department of Health and other relevant stakeholders to ensure the smooth implementation of your research activities. Throughout the course of your study, you are expected to adhere to the highest ethical standards, safeguard confidentiality, and respect all institutional and community protocols.

Upon completion of your research, you are kindly requested to submit a copy of your final report or thesis to the County Government. This will aid in informing policy formulation and the development of programmatic interventions aimed at strengthening community health services in the County.

We extend our best wishes for your academic endeavours and look forward to the valuable insights your study will provide in advancing healthcare delivery in Nandi County.

Yours Sincerely,

A handwritten signature in black ink, appearing to read "Francis K. Sang".

Dr. Francis K. Sang, MBS

COUNTY SECRETARY & HEAD OF COUNTY PUBLIC SERVICE

Appendix 5: NACOSTI Licence

 REPUBLIC OF KENYA Ref No: 656187	 NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION Date of Issue: 20/May/2025
RESEARCH LICENSE	
This is to Certify that Ms. CHEBET RISPHER of Kenya Methodist University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nandi on the topic: FACILITATORS OF COMMUNITY HEALTH PROMOTERS SERVICE PROVISION: A CASE STUDY OF NANDI COUNTY for the period ending 20/May/2026.	
Applicant Identification Number 656187	License No: NACOSTI/P/25/4173605 <i>Galenz</i> Deputy Director NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION
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THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)
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The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

CONDITIONS OF THE RESEARCH LICENSE

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to.
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
 - i. Endanger national security
 - ii. Adversely affect the lives of Kenyans
 - iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
 - iv. Result in exploitation of intellectual property rights of communities in Kenya
 - v. Adversely affect the environment
 - vi. Adversely affect the rights of communities
 - vii. Endanger public safety and national cohesion
 - viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. Neither the license nor any rights thereunder are transferable.
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

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