FACTORS INFLUENCING COMMUNITY PARTICIPATION IN HEALTHCARE PROGRAMS: A CASE OF SIAYA COUNTY, KENYA

BY

EDWARD OMONDI OCHIENG'

A Research Project Report Submitted in Partial Fulfillment of the Requirement for the award of the degree of Master of Arts in Project Planning and Management of the University of Nairobi

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DECLARATION

This research project is my original work and has not been presented for a degree in any other university.

Edward Omondi Ochieng Date………………………………….

L50/62281/2011 Signature……………………………

This research project has been submitted for examination with my approval as the university supervisor.

Mr. Augustine Mwangi Date………………………………….

University of Nairobi Signature……………………………

` DEDICATION

I dedicate this project to my parents Jackton Richard Ochieng and Mary Aoko Ochieng for their inspiration and unlimited support.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Ante-Natal Care
CBD	Community Based Development
CBFP	Community Based Family Planning
CBHC	Community Based Health Care
CI	Confidence Interval
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
ITNs	Insecticide Treated Nets
KAIS	Kenya Aids Indicator Survey
KEPI	Kenya Expanded Program for Immunization
KNBS	Kenya National Bureau of Statistics
KEPH	Kenya Essential Package for Health
NGOs	Non Governmental Organizations
NHSSP	National Health Sector Strategic Plan
PHC	Primary Health Care
STI	Sexually Transmitted Infection
US	United States
WHO	World Health Organization

ABSTRACT

The concept of strengthening community action within the context of disease prevention is gaining popularity among health cycles. In Kenya for example, key stakeholders in health sector have recognized the benefits of multi-sectored response to health issues based on partnership among stakeholders. This study examined the factors influencing community participation in Kenya with particular reference to healthcare programs in Siaya County. The specific objectives of the study were: To determine the influence of capacity building on community participation in healthcare programs in Siaya County, To ascertain the influence of culture on community participation in healthcare programs in Siaya county, To establish the influence of attitude on community participation in healthcare programs in Siaya County and To assess the influence of socio-demographic factors on community participation in healthcare programs in Siaya County. The study was of significance to the management of healthcare programs in Siaya County, the government, other stakeholders and the researcher in understanding the factors influencing community participation in healthcare programs in order to assist in developing regional strategies and effective policies targeted at improving involvement in governance of healthcare. The descriptive survey targeted 267 staff across the constituencies of Siaya County. Primary data was collected through the use of semi-structured questionnaires. Descriptive and inferential statistics were carried out with SPSS version 20; qualitative data was grouped into themes and analyzed. Regression analysis was used to determine the strength of association of socio-demographic factors and level of involvement and contribution of capacity building and culture to community participation using coefficient of regression (r), level of significance being at 0.05 ($P< 0.05$) at 95% CI. More males (OR=5.56, 95% CI=3.65-8.63) were involved in decision making regarding healthcare than their female counterparts (OR= 2.54, 95% CI= 0.54-3.24). Participants who had more years in education were more likely to participate in the healthcare programs than those with less education. Capacity building was found to contribute more when appropriate technology was used (m= 2.111, sd= 0.89499) and when there was adequate representation of all stakeholders in the process (m= 2.2444, sd= 0.88306). Cultural factors were the major barriers to community participation. Community involvement and participation in health programs is key to sustainable development in Siaya County. Strategies should be sought to address the challenges identified in this study to foster community participation and ownership of health programs thus improving health services utilization with improved health outcome.

Programs should be locally led and managed by local healthcare professionals, supported and assisted by community health workers. A comparative study of this study should be carried out to compare the findings in urban areas.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The concept of strengthening community action within the context of disease prevention is gaining popularity among health cycles. According to WHO (2004), community participation in healthcare is a core element of health which requires going beyond consultation to enable citizens to become an integral part of decision making and action process (WHO, 2004). In developing countries, the concepts of health promotion, self care and community participation are still in infancy (Rifkin, 2009) with some of the challenges experienced by health workers attempting to facilitate meaningful participation in decision making relating to lack of clarity in defining the concepts of community and participation and the range of processes participation encompasses (Butterfoss, Goodmann., & Wandersmann, 2003, Rifkin, 2009). Historical profiles of these nations record an increased number of NGOs during the eighties and nineties but they often tended to focus on how much to deliver rather than on what to deliver. The language of participatory development was increasingly couched in terms of effectiveness, efficiency and sustainability, putting the accent of professionalism and technical capacity to deliver (Curtis, 2005)

Participation concepts are an expression of the move towards the so called people centered development and are integrated into policies of many donors and NGOs emphasizing the importance of self help (Hausermann, 2003). In Kenya for example, Key stakeholders in health sector have recognized the benefits of multi-sectored response to health issues based on partnership among stakeholders. This has led to considerable changes in programming including a shift from largely health facility based activity to greater balance between health facility and community based interventions. There has been greater involvement of communities including beneficiaries, civil society and private sector. However, gaps abound regarding optimal approaches for coordinating and harmonizing the response while fostering genuine involvement and empowerment of communities (KEPH (Kenya Essential Package for Health) 2013-17) (Kenya Health Sector Strategic and Investment Plan (KHSSP) 2013-17).

With the dialogue around policies for health today placing much discussion on specifically those living in poverty, participation is not only promoted in the context of provision of and utilization of health services. Advocates also highlight participation as a key factor in the wider context of importance of social determinants of health and health as a human right (Rifkin, 2009,WHO, 2008). Despite the growing interest in the role of participation, there is little concrete evidence that links participation directly to better health outcomes (Rifkin, 2009). The absence of this link

continues to be a barrier to gain full support of governments, funding agencies and health professionals to promote this approach (Atkinson, Vallely, & Fitgerald, 2011). As a result, community participation as a guarantee for uptake and support for local health services has not been reaffirmed just like Berman et al (Berman, Gwatkin, Burger, 1987) and Walt (Walt, 1990) reported.

A baseline assessment undertaken by AMREF, (2004) in the Lake Victoria Basin region of Kenya and follow up assessment undertaken one year later (AMREF, 2005) revealed that the country's HIV/AIDS response was hampered by constraints in five areas; coordination, community capacity, participation of community in HIV/AIDS mitigation, availability of resources to communities and challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most at-risk categories of Kenya's population. These findings corroborate those found in other assessments of Kenya's post national response to HIV/AIDS (Delion, 2004).

It is clear that despite the proposed benefits of participation, and establishment process, in practice, few people participate when given the opportunity (Bracht and Tsouros, 1990). As Goodman, Chinma, & Morrissey, (2008) conclude, difficulties in defining the relevant concepts of community participation have contributed to many community health programs having the cloak of a new community based approach under with the traditional health care system remains (Goodman et al, 2008).

Siaya county is situated in Kenya, along the shores of lake Victoria and it borders Busia, Kisumu, Vihiga and Kakamega counties. It covers an area of 2,350 square kilometers with a population of 842, 304 people as per 2009 census. Politically, it is organized into 5 constituencies namely: Ugenya, Alego-Usonga, Gem, Bondo and Rarieda and is easily accessible by air, road, water and rail (Kenya: County fact sheets, 2012).

According to Matibabu Foundation Kenya (2010), Siaya County has fallen behind most national health indicators. Women and children bear heaviest burdens of malaria, HIV/AIDs and other preventable diseases. Owing to its high fertility and declining mortality, the county is characterized by a youthful population and consequently faces the formidable challenge of providing its youth with opportunities for a safe, healthy, and economically productive future.

1.2 Statement of problem

Even though technical solutions exist for preventing disease complications, their implementation has been fragmented with limited population impact due to other limiting factors that come in the way of the consumers of such services (WHO, 2004). A good case scenario is the immunization coverage within Siaya County which remains low despite a well established and supported KEPI (KDHS, 2009). The results of KDHS (2009) showed that the county has a high level of under-five and infant mortality rates with almost one in seven children dying before attaining age of five (149/1000) and even more higher in some divisions like Karemo with 184/1000 deaths (Otieno J, 2013). According to KNBS (1999), infant mortality rate in Siaya district alone stood at 135.6 and under five mortality at 234/1000. Integration of community (level 1) with the formal healthcare (community strategy) that could increase the continuum of care requires participation of both the community and the health system and is key to achieving universal access to health care as envisaged by the WHO Alma Ata conference of 1978. It is also key to a reduction to maternal and child mortality including AIDs related deaths. However, with the weakened health systems, increased poverty and inadequate link of participation and health outcomes, the way forward is uncertain. It is important to understand social, cultural and organizational factors that hinder participation and involvement. Effective strategies could be formulated to promote access to program components by the community. Therefore, this study aimed to explore factors that influence genuine community participation in healthcare programs in Siaya county. This study will give informative knowledge aimed at providing the basis for future interventions.

1.3 Purpose of the study

The purpose of this study was to determine the factors influencing community participation in healthcare programs in Siaya county.

1.4 Objectives of the study

The study was guided by the following objectives:

1. To determine the influence of capacity building on community participation in healthcare programs in Siaya county.
2. To ascertain the influence of culture on community participation in healthcare programs in Siaya county.
3. To establish the influence of attitude on community participation in healthcare programs in Siaya county.

4. To assess the influence of socio-demographic factors on community participation in healthcare programs in Siaya County.

1.5 Research questions

1. To what extent does capacity building influence community participation in healthcare programs in Siaya county?
2. How does culture influence community participation in healthcare programs in Siaya county?
3. What is the influence of attitude on community participation in healthcare programs in Siaya county.
4. To what extent do socio-demographic factors influence community participation in healthcare programs in Siaya county?

1.6 Significance of the study

As the country toddles towards implementation of the regional governments, the results of this study may be useful in constructing local participatory strategies and programs aimed at tackling local health problems in this region of the country. Consequently, the results of this study may also be applicable in planning for health programs in different regions of the country with the same geographic and socio-economic characteristics with the aim of improving healthcare.

It is hoped that the study will also be important in helping international institutions like WHO reach their targets in the PHC vision by making them focus their activities in different sub regions of the country rather than the whole country. In addition, it will be useful to other researchers especially in continuation of various studies that are related to this project. Alternatively, the study will also be useful to those researchers with inexperienced skills of developing research studies. They will make this study a source for their reference and also benefit future comparisons.

The government will also find the information useful by identifying the weaknesses of health programs implementation in Siaya County and come up with possible solutions which will enhance community participation practices. The study provides knowledge networks which present clients with the highest quality standards for the government to adopt as it provides the scientific integrity required in today’s research environment.

1.7 Limitations of the study

The first limitation was poor accessibility of some parts of the proposed study area due to poor infrastructure especially in the villages that neighbor swampy areas. This limitation was overcome by using the appropriate mode of transport to access areas that are not accessible by vehicles. The area is also very vast and there was that aspect of time and financial limitations.

1.8 Delimitation of the study

The scope of this study comprised of carrying out research based on the factors influencing community participation in healthcare programs in Siaya County. This involved undertaking an in-depth study based on capacity building, community culture and attitude. The target population was the staff working in the public hospitals in the county, assistant chiefs, and community group leaders. Descriptive survey research methodology was adopted relying on purposive and random sampling as the main sampling techniques. Finally, the study was delimited to questionnaires as the instruments of data collection.

1.9 Basic assumptions of the study

In the study, the following assumptions were made:

That the participants were able to respond and actively participate in the data collection procedure and that research assistants were able to reach all the respondents on time and that authority concerned offered maximum cooperation.

That, research assistants were able to collect the entire filled in questionnaires and submit to the researcher on time.

1.10 Definition of significant terms

Community: A group of interacting people, living in some proximity (i.e. in space, time, or relationship). Community usually refers to a social unit larger than a household that shares common values and has social cohesion. The term can also refer to the national community as international community.

Community participation: Is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people.

Capacity building: Is the act of helping citizens and communities to acquire the confidence, skills and power to enable them to shape and influence their local place and services, alongside providing support to national and local government agencies to develop, promote and deliver effective engagement and empowerment opportunities.

In this sense, it is conceptualized as an ongoing process of influencing and enhancing change agents knowledge, skills, attitudes and ultimately their practices in order to enable them cause similar effect and impact on the people and communities they serve.

Community empowerment: Is the process of enabling people to shape and choose the services they use on personal basis; so that they can influence the way those services are delivered. It is often used in the same context as community engagement, which refers to the practical techniques of involving local people in local decisions and especially reaching out to those who feel distanced from public decisions.

Mobilization: Is a process whereby a group of people transcend their differences to meet on equal terms in order to facilitate a participatory decision making process. It is a process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups and organizations on a participatory and sustained basis to improve the health, hygiene and education levels.

Culture: Is the shared set of beliefs, expectations, values, desires and rituals that influence the ways in which individuals, groups and teams will interact with one another and collaborate to achieve common objectives as far as health care is concerned.

Attitude: Is learned predisposition to respond in a favorable or unfavorable manner to participatory mechanisms, objects as well as more abstract issues.

1.11 Organization of the study

The research project is organized into five chapters. Chapter one is the introductory chapter that gives an overview of the study. It contains the statement of the problem, justification of the study, scope among others. Chapter two contains literature review from past researches and also the conceptual framework and chapter three explains the methodology of the study. It outlines the research design, the target population, sampling techniques, data collection instruments, data collection and analysis techniques. Chapter four elaborates on data analysis, data presentation, interpretation and discussion of the findings which have been obtained from the study,

conclusions as well as the recommendations based on the findings. Chapter five outlines the summary of findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of literature on community participation in healthcare programs, it comprises of theoretical review, conceptual framework and summary of literature review to be addressed.

2.2 Capacity building and community participation

Capacity building entails a continuous process of enhancing stakeholders' knowledge and skills as well as adjusting stakeholders' attitude, values and practices (Laverack, 2008). Communities are groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interests. Capacity building refers to the process by which people gain control over the factors and decisions that shape their lives. It is the process by which they increase their assets and attributes and build potentials to gain access, partners, networks and/or a voice, in order to gain control. Enabling implies that people cannot be empowered by others; they can only empower themselves by acquiring more of power's different forms. It assumes that people are their own assets, and the role of the external agent **is** to catalyze, facilitate or accompany the community in acquiring power.

Capacity building, therefore, is more than the involvement, participation or engagement of communities. It implies community ownership and action that explicitly aims at social and political change. Capacity building is a process of renegotiating power in order to gain more control. It recognizes that if some people are going to be empowered, then others will he sharing their existing power and giving some of it up (Baum, 2008). Power is a central concept in capacity building and health promotion invariably operates within the arena of a power struggle. Capacity building necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions. Globalization adds another dimension to the process of capacity building. In today's world, the local and global are inextricably linked. Action on one cannot ignore the influence of or impact

on the other. Capacity building recognizes and strategically acts upon this inter linkage and ensures that power is shared at both local and global levels.

According to Waisbord, (2005) communication plays a vital role in ensuring capacity building. Participatory approaches in communication that encourage discussion and debate result in increased knowledge and awareness, and a higher level of critical thinking. Critical thinking enables communities to understand the interplay of forces operating on their lives, and helps them take their own decisions. Community Based Development puts grassroots people (communities) at the centre of the development processes. Communities cease to be passive beneficiaries of the desired change and instead become drivers of that change. This transformation is a continuous internal process that builds on the human and social capital that exists in a community, a process that may also be accelerated by outside assistance.

The primary purpose of CBD is to help individuals and communities to gain greater control of their lives by giving those opportunities and resources to develop knowledge, skills and motivation to pursue positive change at personal or community level. CBD is applicable to development in all sectors (Goodman, 2000). In public health, it is commonly referred to as Community-Based Health Care (CBHC). This is a community-driven and community based approach to Primary Health Care that empowers individuals and communities to improve their health and quality of life. It is holistic in that it encompasses preventive, promotive, and curative components of community health. It is supposed to link the community and the formal health care system. Undoubtedly, the main pillar of CBHC is the people's active participation in the promotion of health, prevention of disease and management of common ailments at community level. The challenge however is that most communities in Africa, particularly marginalized ones, need outside expertise and economic assistance to catalyze such development (Mulwa, 2004).

The ultimate goal of Community Based Development is to improve the quality of life in the community. There are numerous examples in the world where its application has had a positive impact on people's lives. For instance, the Jamkhed Comprehensive Rural Health Project in India helped impoverished communities to define their development priorities and to nurture the community's own human resources to address these priorities. In this case, child mortality was

reduced drastically as a result of the role of community health workers. (Laverack, 2008). In India too, the Society for Education, Action and Research in Community Health has recorded massive benefits in overall community health as a result of participatory processes focusing on local initiatives. And in Nigeria, the Rural Health Program combined capacity building, rural health and sustainable agriculture, with local people taking the lead in the situation analysis, prioritization of needs, project planning and implementation, as well as monitoring and evaluation. The outcome after five years indicated improved health and welfare of the communities.

Examining the contribution that capacity building has made to health improvements, Wallerstein (2006), in her view of health and empowerment, concludes that capacity building helps people to act collectively, challenge power inequities and gain outcomes in a range of domains, including greater access to resources and transforming institutes. In the conceptual realm, the work of the Nobel prize winning economist Amartya Sen has led cutting edge thinking about how the capabilities and choices of the poor must be expanded to ensure a greater opportunity to improve life chances (Sen A, 1999).

The capacity building discourse has been greatly influenced by advocates for health as a human right. The people's health movement is based, according to its charter on health as human right (People's Health Assembly. People's Charter and Health; People's Health Movement, 2000). Since that time, it has mobilized groups throughout low, middle and high income countries to take up causes such as the closure of pollution causing businesses, access to healthcare, food sovereignty and the rights of political prisoners. Its emphasis has been to develop the decision making capacities of the underprivileged in order that they may exercise their power to gain specific demands, and to give people confidence to act for their own improvement. The activities of such civil society groups have influential policy promulgation at the international level, particularly in the Pan American Health Organization. Its document on renewing PHC, published in 2007 (PAHO, 2007), highlighted human rights and community participation in terms of solidarity, an emphasis that was not mirrored by the WHO, (World Health Report, 2000). All these experiences substantiate the lesson that there is no standard definition for community participation and that the political context is critical. They also illustrate that the definition of the terms remain flexible and fluid, reflecting change in both local and global dialogue.

Community involvement or mobilization can lead to better community-based family planning (CBFP) programs and outcomes. Community members have the best understanding of their own culture, norms, beliefs and traditions. Thus, participation by community members can assist in more relevant, cost effective, gender equitable and socially equitable CBFP programs, (Sarkar, 2010). This in turn, leads to increased community support and demand for family planning. Community mobilization is defined as a capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis.

Communities suffering from the HIV epidemic are generally socially marginalized and even criminalized. High-risk populations include individuals who frequently engage in dangerous behaviors, such as injecting drug users, sex workers, transgender, or men who have sexual relations with other men. Because these cohorts are often socially isolated, it is challenging for them to access healthcare through mainstream services. According to Obregon and Waisbord, (2010) the mission of community friendly clinics was developed to provide outreaches where the patients feel comfortable obtaining health services. A spectrum of resource suppliers would assist in running these clinics, including personnel such as private practitioners, community organizations, NGOs and even government bodies. However, community engagement and uptake of these intervention services is extremely complex. Social and political frameworks marginalize these target populations, and the open acknowledgement or discussion of these pivotal issues is often avoided by politicians.

Social mobilization evidence has shown us that in order to succeed in attaining sustained behavioral changes, services must be driven by the people instead of driven by targets. For example, in Thailand and Cambodia, HIV prevention campaigns have followed this model successfully. The acute pervasiveness of HIV was overturned by involving brothel owners and other authorities instead of only sex workers themselves. Shortly after this success story occurred, multiple agencies in Asia offered financial backing for STI testing sites and condom distribution without carefully noting the factors that influence use and acceptance, therefore making this approach significantly less effective, (Pattanayak , 2009). Another surge of programs arose from the Sonagachi project that demonstrated successful community mobilization,

organization, and general approval of the intervention methods from locals. This ultimately led to increased rates of condom utilization and decreased rates of HIV infection among the target population.

Haggstrom, (2010) indicated that Polio Eradication Initiative stands out as one of the most determined global health endeavors currently, and social mobilization is a key element to accomplishing this. The application of social mobilization in this area has concentrated on vaccination promotion to increase uptake of vaccine services during National Immunization Days especially in countries that suffer from crumbling health infrastructures and poor immunization rates. During National Immunization Days, social mobilization has primarily relied on the efforts of local health employees and community volunteers to provide the oral polio vaccine, media promotions to inform the community about the numerous advantages of getting vaccinated, documentation of unimmunized youth per household and follow-up observations of cases. These interventions have involved a multitude of local organizations, including those that are educational, religious, and business-affiliated. Worldwide, approximately ten million people have contributed to the polio immunization social mobilization effort.

Community involvement in polio eradication has also assisted other local health initiatives. For instance, local systems and infrastructure established by the polio intervention have also been used to support other health programs, such as measles immunization, deworming campaigns, avian influenza control, and community surveillance. Examining the essential features of the polio eradication initiative can assist in determining the remaining obstacles to polio eradication and will allow for further exploration about the complexity of social mobilization, (Obregon and Waisbord, 2010).

An ongoing debate exists as to whether sanitation conditions and uptake of other health services can be better improved by providing monetary subsidizations, or by using emotional motivators. Those who support the funding theory argue that poor individuals are most limited by their lack of income and need financial assistance more than anything else. The other side of the argument consists of shaming proponents, who are strongly convinced that permanent changes in behavior

require inherent motivation, and that people are more likely to use and value what they have paid for, (Sarkar, 2010). In rural Orissa, India, shaming techniques and subsidy techniques were used together in low-income households. The intervention was driven by community needs and led by local people, but was applied by state governments. The campaign engaged a multitude of community members, offered economic compensation to meet the program mission, and encouraged populations to define their own objectives to accomplish. There was widespread hope in Orissa that the Total Sanitation Campaign would be able to improve the uptake of household latrines and therefore reduce rates of open defecation.

This successful social mobilization can be described in terms of the four social marketing P's:the product being sold was not only health, but also the attitudes and feelings about privacy and dignity associated with household latrines: the placement refers to the campaign effects that came from local motivators' door to door promotions; promotion is embodied by the social pressure and peer monitoring of the community and overall inertia of the intervention; and price includes the subsides that were combined with shaming techniques in order to succeed. While subsidies are not always required to ignite action, they are extremely helpful when used along with social pressure approaches such as shaming in the Indian culture. (Obregon and Waisbord, 2010).

2.3 Culture and community participation in healthcare programs.

In order to catalyze behavioral changes at a societal scale, health education programs must address the cultural and social dimensions of health care. This means that healthcare necessities will not be used unless accompanied by effective and culturally appropriate education. When working in a different cultural and social context, it is necessary to engage with a community "from within" in order to build an environment of trust, (Holden, 2007). Culturally appropriate education efforts are tailored and framed from the perspective of the target community. Thus, to develop a culturally relevant education program, one must engage strategically with local culture to look at the way in which culture influences lifestyle and behavior.

Chang, Condon, Baker, Bloem, Savage & Sommer., (2000) noted that implementing a healthcare education initiative without an adequate understanding of the local culture can be counter-productive, giving rise to more problems than solutions. For example, when working in a new

cultural environment, health workers cannot assume that other cultures readily share, or are ready to submit to, their philosophies and belief systems. There are implicit power relations at work in many cultures that can hinder effective health care delivery if they are not taken into account during program planning.

One way to ensure that health education efforts are culturally appropriate is to develop programs that are locally led and managed by local healthcare professionals, supported and assisted by community health workers. The Community Health Workers may be family members, friends, or even patients who provide health education, refer people who are ill to a clinic, or deliver social support to patients in their homes. While they do not supplant the work of doctors or nurses, they are a vital interface between the clinic and the community (Thomas, Stephen, Michael, & Said., 2004). Above all, community health workers are crucial to the success of global health efforts because of their unique understanding of local problems. Their close community ties allow them to identify areas of need and to effectively navigate potential barriers that others may not be positioned to understand. By leading education campaigns in their communities and raising awareness regarding health issues, community health workers are more trusted and better able to encourage community members to take charge of their own health.

Partnering with local doctors is essential for efficient and effective healthcare delivery. The needs of the local community are best known by those who have an understanding of the local situation. Local providers are familiar with the etiologies and distributions of diseases in their communities, (O'Neil, 2006). They are also aware of regional aspects of public health such as hospital patterns, which has access to care, and how to best distribute resources. Additionally, many Western physicians are unfamiliar with local disease and must rely on the expertise of local doctors to make correct diagnoses and dispense effective treatments. Integrating local doctors into global health programs is essential for sustainability. A global health program that does not seek to support local healthcare providers can only yield temporary improvements, if any. Long-term improvements in community health require follow-up care, ongoing care, and broadening the reach of local doctors' practices so that more patients have access to care year round, (Ware et al, 2009).

Failure to involve local doctors in global health programs can yield deleterious results. For instance, medical treatment without follow-up care can be more harmful than helpful, and foreign medical providers unfamiliar with cultural norms often struggle to communicate with patients. More importantly, excluding local doctors subverts community trust in local healthcare programs. Dr. Edward O'Neil, Jr. (2006) notes that in spite of their expertise, there exists a widespread belief among locals and foreigners alike that local doctors are "inferior clinicians." This belief is reinforced when Western physicians refuse or neglect to collaborate with their local counterparts. Undermining the legitimacy of local doctors can only harm community health.

The local environment of each target community varies widely, each presenting unique challenges to the delivery of health care. This means that health education efforts must be locally conceived, tailored, and implemented, (Holden, 2007). Barriers to accessing care are widespread in developing countries and require innovative strategies to overcome them. The healthcare field is complex in nature, requiring trained professionals and follow up care to ensure adherence to drug regimens and resource limitations make it essential to assess the impact of programs through metrics. In order for global health programs to be effective, these complexities must be recognized, understood and addressed.

2.4 Attitude and community participation in healthcare programs

Community psychology studies attitude in relationship to individual's contexts within communities and the wider society, and the relationships of the individual to communities and society. (David, Mark, Michael, Brian & Emee, 2011). It seeks to understand the quality of life of individuals, communities, and society. Its aim is to enhance quality of life through collaborative research and action. It employs various perspectives within and outside of psychology to address issues of communities, the relationships within them, and related people's attitudes and behavior. Michie and Abraham (2004) discuss the perspective of community psychology as an ecological perspective on the person environment fit (this is often related to work environments) being the focus of study and action instead of attempting to change the personality of individual or the environment when an individual is seen as having a problem.

It is generally agreed that the target population must have a positive attitude to their project or program and play a leading role in the selection and implementation of the project. Olujide, (2008) carried out a study to investigate attitude of the youth towards rural development projects in Lagos state, Nigeria. Olujide specifically focused on personal characteristics of the youth, the role played by youth and attitude of the youth towards rural development projects. The results of the study showed that majority of the respondents belonged to youth organizations and participated in rural development projects.

The study further revealed that educational level did not have any effect on the respondents' action towards rural development, but attitude and culture had an impact on the level of participation of respondents in rural development projects. On youth involvement in rural development projects the study shows that 71.2% of the respondents were involved in the development projects. On membership, 71.2% of the respondents belonged to one organization. On mode of participation, majority (62.5%) of the youth were actively involved in rural development project in one way or another while less than half (37.5%) were not participating. On the operations of the youth in development projects, 42.5% were involved in building schools, 20% in road construction; while the remaining 15% were involved in hall construction and sanitation facilities. Based on the data, Olujide concluded that the youths were highly motivated and had a positive attitude; hence projects in the area will highly be maintained. Favorable attitude of the youth in the area towards-rural development projects signifies better approach to the development of the area (Olujide, 2008).

Attitudes and perception of mothers and caretakers of the children are thought to be strong determinants of immunization completion (Coreil et al., 1989). Attitude refers to the manner, disposition, feeling, position etc with regard to participation in healthcare programs.

Myths arising out of inadequate or complete lack of knowledge and misinformation have been identified as barrier against community participation (Begg and Nicoll, 1994). This is in agreement with a study among economically disadvantaged group in the US (Bates, 1998) which showed that mothers misperception on benefits of immunization is related to under vaccination of children below 2 years. Bates revealed that mothers often expected that their children would not fall sick after vaccination and therefore have lost faith in immunization. Immunization is only able to prevent specific diseases and therefore it is not possible that vaccination can prevent all diseases. This is therefore a typical case of lack of good knowledge on the benefits and reasons for immunization that has affected the perception and attitude of mothers towards childhood immunization.

Abdulraheem, (2011) in Nigeria also demonstrated that mothers who had culturally influenced negative attitude about health facility were 2 times more likely to have incompletely vaccinated children than mothers who had positive attitude. This finding is also supported by Coreil, Augustine, Holt & Hasley (1989). It was also evident according to Schwars, (2009) that in Gabon mothers were very positive about vaccination despite the fact that there is confusion on whether vaccinations cure or just prevent diseases.

Health psychologist's work towards promoting health through behavioral change; however, they attempt to prevent illness in other ways as well. Campaigns informed by health psychology have targeted tobacco use. Those least able to afford tobacco products consume them most. Tobacco provides individuals with a way of controlling aversive emotional states accompanying daily experiences of stress that characterize the lives of deprived and vulnerable individuals. Practitioners emphasize education and effective communication as a part of illness prevention because many people do not recognize, or minimize, the risk of illness present in their lives, (Ick and Tetrick, 2003). Moreover, many individuals are often unable to apply their knowledge of health practices owing to everyday pressures and stresses. A common example of population based attempts to motivate the smoking public to reduce its dependence on cigarettes is anti-smoking campaigns. Health psychologists also aim at educating health professionals, including physicians and nurses, in communicating effectively with patients in ways that overcome barriers to understanding, remembering, and implementing effective strategies for reducing exposures to risk factors and making health-enhancing behavior changes.

Critical health psychologists explore how health policy can influence inequities, inequalities, and social injustice. These avenues of research expand the scope of health psychology beyond the level of individual health to an examination of the social and economic determinants of health both within and between regions and nations, (David et al., 2011). The individualism of mainstream health psychology has been critiqued and deconstructed by critical health psychologists using newer qualitative methods and frameworks for investigating health experience and behavior.

According to Sharman, (2008) health psychologists studying attitude attempt to aid the process of communication between physicians and patients during medical consultations. There are many problems in this process, with patients showing a considerable lack of understanding of many medical terms, particularly anatomical terms (e.g., intestines). One main area of research on this topic involves 'doctor centered' or 'patient-centered' consultations. Doctor-centered

consultations are generally directive, with the patient answering questions and playing less of a role in decision- making. Although this style is preferred by elderly people and others, many people dislike the sense of hierarchy or ignorance that it inspires. They prefer patient centered consultations, which focus on the patient's need, involve the doctor listening to the patient completely before making a decision, and involving the patient in the process of choosing treatment and finding a diagnosis.

Getting people to follow medical advice and adhere to their treatment regimens is a difficult task for health practitioners. People often forget to take their pills or consciously opt not to take their prescribed medications because of side effects. Failing to take prescribed medication is costly and wastes millions of usable medicines that could otherwise help other people. Estimated adherence rates are difficult to measure, however, evidence exists that adherence could be improved by tailoring treatment programs to individuals' daily lives, (Michie, 2004).

Michael Gladwell (2005), asserts that the risk of being sued for malpractice has very little to do with how many mistakes a doctor makes. Analyses of malpractice lawsuits show that there are highly skilled doctors who make lots of mistakes and never get sued. At the same time, the overwhelming numbers of people who suffer an injury due to negligence of a doctor never file a malpractice suit at all. In other words, patients don't file lawsuits because they have been harmed by shoddy medical care but they file lawsuits because they've been harmed by shoddy medical care and something else happens to them. It is how they were treated, on a personal level, by their doctor. What comes up again and again in malpractice cases is that patients say they were rushed or ignored or treated poorly. When a patient has a bad medical result, the doctor has to take the time to explain what happened, and to answer the patient's questions-to treat him like a human being (Blink, 2005). The doctors who don't are the ones who get sued. This observation by Malcolm Gladwell emphasizes the importance of a good relationship between healthcare providers and community members. It demonstrates that attitudes develop out of learned behavior between individuals. It is therefore relevant to the present study by linking the behavior of health program implementers and the community attitude and how this influences participation of the community members.

2.5 Socio-demographic factors and community participation in healthcare programs

By examining local social ties using statistical models (logistic and OLS regression), Rebecca and Donald, (2003) were able to identify the characteristics that are strongly related to social networks. Previous studies have found several important factors that influence community engagement and social ties, such as the length of residence, income, education, urban residence and other socio-demographic characteristics. Jordan (2000), and others have speculated that demographic differences between seasonal and permanent residents were responsible for social tensions between groups and lack of community engagement (Gustafson, 2002).

Civic participation is not limited to membership and time spent in community groups. It is also commonly measured by attending public meetings and events, contacting public officials and working on community projects, (Oliver, 2001). Studies, have demonstrated that civic participation by permanent residents of a community have been highly rated than seasonal homeowners. For example, Ladd (2000), reported that 45 percent of Americans attended public meetings in the previous year (compared to 42 percent of permanent residents in the study) and 40 percent of Americans worked on a community project during the previous year (compared to 44 percent of the permanent residents in the study)

The cost of medical care has always been beyond the reach of many living below the poverty line. The United Nations through its Accelerating Access Initiative (AAI) is collaborating with pharmaceutical corporations to help drive anti-retroviral drug prices down. Backed by a strong social commitment, few countries like Brazil, Argentina, Uruguay and Botswana are providing HIV/AIDS patients free anti-retroviral drugs (UNAIDS/WHO, Dec, 2001). Presently, the government of Kenya has taken the initiative of providing free HIV/AIDS control drugs to all HIV positive patients.

Although the pharmaceutical companies have come up with the generic triple drug cocktail at low prices, it is still by no means affordable for poor people who live on a day to day basis. Ironically, it has also been reported that majority of those who need these drugs do not get them due to the fact that the companies export their drugs to other countries. This all shows the

disparity that exists within the social stratifications whereby engagement in certain activities that are vital to survival run alongside socio-economic capabilities.

2.6 Theoretical framework

This study was anchored on the ‘Frozen Community Theory’ which assumes that communities have potential for self mobilization and self-development. However, research tends to point out that communities will often fail to realize this potential because of ‘inertia’. Conflicts and competition within families and among community members has tended to usurp the energies that could have been utilized for constructive purpose and common good. This reality, coupled with the limited exposure for the larger numbers of rural communities, has led to ‘passivity’. The often authoritarian political systems and unaccountable local leadership are part of the factors that constellate together to reinforce people’s inertia. This explains the state of fear and despondency which often characterize ‘frozen’ communities.

In the frozen community are the local structures which have to be recognized and acknowledged by the foregoing set of change agents. Recognition of these structures serves to legitimize future development initiatives within the community. Without such legitimacy, one would be sure to get it wrong right from the community entry stage. Such structures include the chiefs, political power brokers (gatekeepers), religious leaders, community elders and clan elders.

The world development

Agents

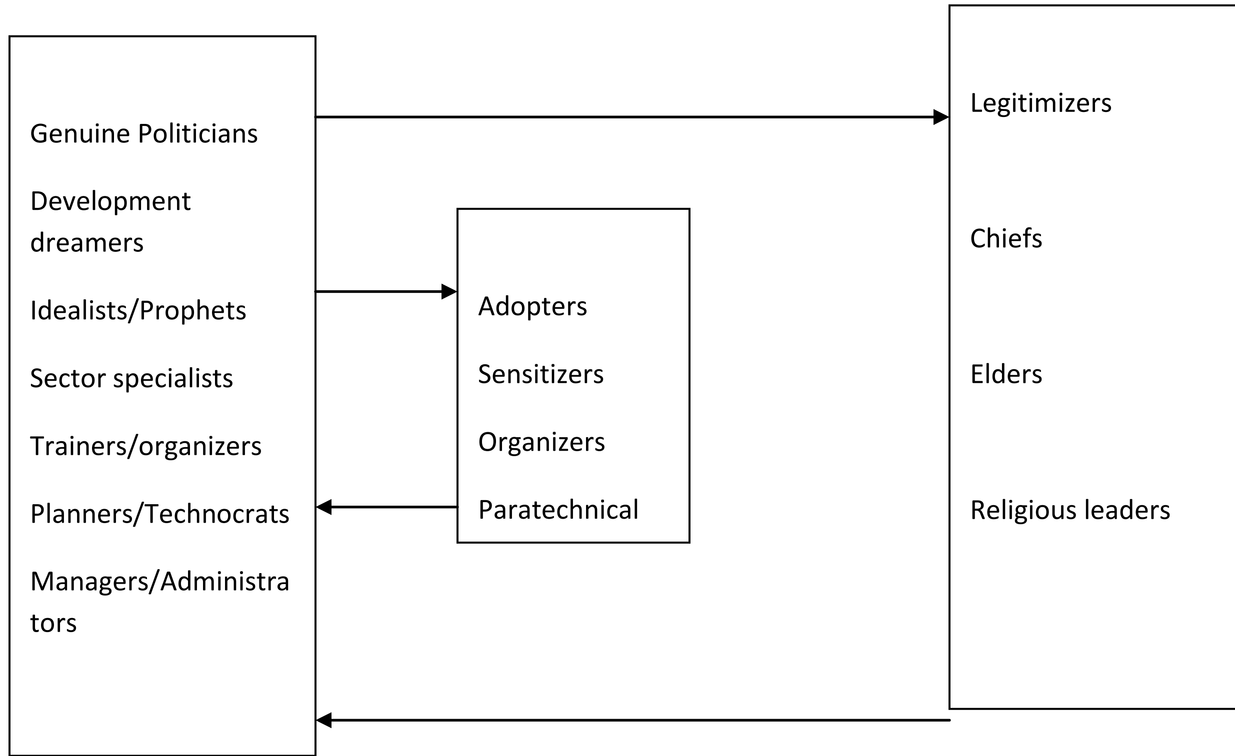

Fig 2.1 Theoretical framework

2.7 Conceptual framework

Conceptualization process is important in determining what to measure, in order to investigate the factors influencing community participation in healthcare programs in Siaya County. This section summarizes the framework or the model of the study in terms of variables relationships. The main variables of the study are capacity building, culture attitude and socio-demographic factors. The variables are considered in the study as independent variables which influence community participation in healthcare programs in a Siaya county. This is presented in the figure 2.2

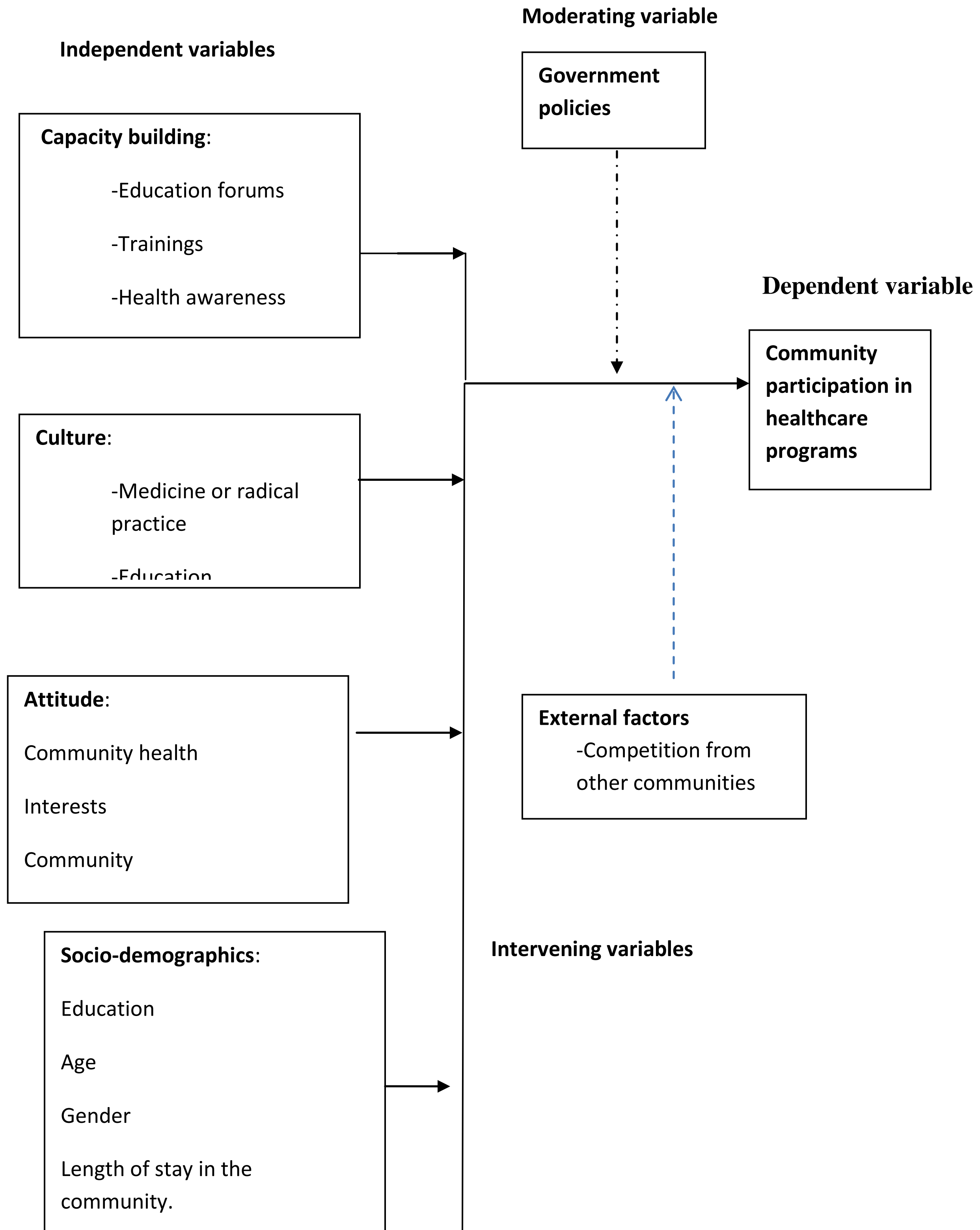

Figure 2.2 Conceptual framework

2.8 Knowledge gap

There are few published studies on community participation in healthcare programs in Kenya and the practice of assessing community participation is very rare. This prompted the descriptive study to measure the level of engagement of the community with the health programs designed for them to advice partners and ministry of health for efficient planning and construction of local participatory strategies aimed at tackling local health problems. Outcomes of the study would be a significant step in the direction of evidence based health service provision and an influence of policy change.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents a detailed description of how the requisite data was sourced, processed, analyzed and interpreted to fulfill the research objectives. The methodology elements considered in this chapter include the study design that was applied, the area of study, the target population, the sample size and sampling procedures that were employed, data collection instruments, validity and reliability of the instruments, data collection methods and data processing and analysis techniques used.

3.2 Research design

The study adopted a descriptive research design to determine and report findings the way they were. It attempted to describe as much as possible factors such as behavior, attitudes, characteristics and values (Mugenda and Mugenda, 2003). The design was used to obtain information concerning the current status of the group, to survey what exists with respect to the conditions in the situation.

Descriptive research design was the most appropriate for this study because the researcher did not have the capacity to manipulate at will the variables under study. It helped the researcher to obtain information concerning the current status of the community and thus relate it to the objectives of the research and therefore make it relevant to the research questions as well as getting the correlation between healthcare challenges, and alternative sources to capacity building and community culture.

The context of the topic for the study called for both qualitative and quantitative data that formed the basis for descriptive design to be used to obtain summary measures to address the research questions. This study thus, used quantitative and qualitative research methodologies and analysis. This was in agreement with Patton's (1988) claim for a positivist view of research, which is about using the approach which the researcher deems most appropriate for the study; each method being adopted appropriately at different stages in the research. The data was collected by two research assistants, and analyzed using SPSS version 20.

3.3 Target population

The target population for the study was all the clinical officers, nurses, assistant chiefs and community group leaders in Siaya county. The accessible population was the clinical officers, nurses, assistant chiefs and community group leaders in the 5 constituencies of Siaya county. Therefore the study sought the views of 267 individuals across the constituencies of Siaya County. The study covered nursing department, clinical department, assistant chiefs and community group leaders making a total population of 267. This is illustrated in table 3.1:

Table 3.1: Accessible population

Constituency	health providers	Ass. Chiefs	Group leaders
Alego	32	40	7
Gem	36	43	6
Ugenya	32	45	4
Bondo	40	39	5
Rarieda	28	33	3
Total	**168**	**200**	**25**

Source: Siaya, Bondo, Rarieda districts development plans (2008-2012)

3.4 Sample size and sampling procedures

Sampling in research is based on selecting a portion of a population to which one wants to generalize (Orodho, 2003). The purpose of sampling is to secure a representative group which will enable the study to gain information about the population. This section discusses sample size and sample selection procedure.

3.4.1 Sample size

The study considered a sample size of 10% of the accessible population since it was descriptive in nature. According to Mugenda and Mugenda (2008), a sample size of 10% is considered adequate for a descriptive study, which means a sample of 53 employees accounting for 10% of

the clinical officers, 10% of the nurses, 10% of the assistant chiefs and 100% of community group leaders was considered adequate. This is illustrated in table 3.2:

Table 3.2: Sample size

Respondents	Frequency	Percentage
Nurses	4	` 10
Clinical officers	4	10
Assistant chiefs	20	10
Community group leaders	25	100
Total	**53**	

3.4.2 Sampling procedure

According to Gay (2003), sampling is a process in which a number of individuals are selected for a study in such a way that the larger group from which these individuals were selected is represented by them. A sample frame of all the constituencies in the county was developed after which a multi-stage sampling was employed to select two constituencies. From each of these constituencies, two health centers were randomly selected. Purposive sampling was then used for clinical officers and nurses. This is because it was not possible to find adequate number of these healthcare providers within the unit of study (health center) to subject them to random sampling. Random sampling was used for assistant chiefs since both the ministry of health and medical services and provincial administration play an equal important role in community participation. Finally, community group leaders were sampled purposively from the constituencies.

According to Mugenda and Mugenda (2003), generalization of research findings largely depends on the degree to which the sample, accessible population and the target population are similar on salient characteristics. If the sample, the accessible population and the target population are similar on salient characteristics, then generalization of the research findings can be made to the target population with confidence.

3.5 Data collection instruments

The study used a semi-structured questionnaires to collect primary data to address research questions and variables such as capacity building and community culture. Questionnaires guaranteed confidentiality as respondents acted without fear or embarrassment. They were simple to administer and convenient for collecting data within a short time (Saunders, 2009). Administration was through drop and pick or by personal administration depending on which method was convenient to the specific respondent.

3.5.1 Piloting of the study

Piloting of the study was carried out in Rarieda (one of the constituencies not taking part in the study and with respondents with similar characteristics as those to be studied). A sample of two clinical officers, two nurses, three assistant chiefs and three community group leaders was selected. (Mugenda and Mugenda, 2003).

Permission was sought from the relevant authorities for pilot testing. The piloting was important for identification and correction of vague questions and unclear instructions. This would assist the researcher to capture the important comments and suggestions from participants and enabled the researcher to improve on the efficiency of the questionnaires. The split halves method was used and repeated until the researcher was satisfied that the questionnaire did not bear variations. It also ensured that quality of the study is fully controlled.

3.5.2 Instrument validity

In general, an instrument is valid if it measures what it claims to measure (Cote, 2002). Content validity of the questionnaires was tested through pilot study. The questionnaires were administered to the respondents in the pilot phase and after filling them, consultations and discussions were held with the supervisor and lecturers in the line of study. After this, changes were made in the questionnaires as necessary.

3.5.3 Instrument reliability

According to Mugenda and Mugenda (2003), reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. The questionnaires were administered to the respondents in the pilot study, filled then collected to test their reliability. The split halves method was used to test reliability. Best and Kahn (1998) state that split halves involve correlating the scores on the odd items of the test (numbers 1,3,5,7 and so forth) against the even items (numbers 2,4,6,8 and so forth). The major advantage of this

approach is that it eliminated chance error due to differing test conditions (Mugenda and Mugenda, 2003). Pearson product – mo**me**nt linear correlation coefficient (r) was then used to test reliability of the questionnaires, as it is the most often used and most precise coefficient of correlation.

Pearson product – moment linear correlation coefficient formula (r)

$$r = \frac{N\sum Y - (\sum(X)(\sum(Y)))}{\sqrt{\{N\sum x^2 - (\sum(X^2))\}\{N\sum Y^2 - (\sum(Y^2))\}}}$$

Where

X = odd scores

Y = even scores

$\sum x$ = sum of the x scores

$\sum y$ = sum of the y scores

$\sum x^2$ = sum of the squared x scores

$\sum y^2$ = sum of the squared y scores

$\sum xy$ = sum of the products of paired x and y scores.

N = number of paired scores

r = correlation coefficient of halves (Best and Kahn, 1998).

Since this correlation coefficient (r) obtained represents one half of the instrument, a correction measure, the Spearman – Brown prophesy was used to establish reliability of the full instrument. Spearman Brown prophesy formula is given by:

$$\mathbf{Re} = \frac{2r}{1+r}$$

Where **Re**= Reliability co-efficient

r = correlation co-efficient between halves.

(Best and Kahn, 1998)

Thus, the scores of the pilot responses were summarized and correlation was therefore determined using Pearson's Product moment linear correlation co-efficient and **r** was established to be 0.90. This product was then subjected to Spearman Brown prophesy formula thus:

Re = 2x0.90/1+0.90

Re = 0.95

The correlation for the pilot study was 0.95 which was considered to be strong indicating the reliability of the instrument.

3.6 Data collection Procedure

Authority to conduct the research in Siaya county was obtained from the Ministry of Public Health and Sanitation (MOPHS). The researcher sought clearance from the County commissioner's office and the Medical Officer of Health (MOH) before commencing the study. Permission was also sought from the facility in-charges to conduct research in their institutions. The task of data collection involved both primary and secondary data. The researcher sought a permit from the National Council for Science Technology and Innovation and an introductory letter from the University of Nairobi to go to the field and collect data once the proposal was approved by the University examination panel.

The researcher recruited two research assistants and trained them on the questionnaire and interviewing skills. During the training each item in the instrument was discussed to ensure that they were well understood.

The researcher and research assistants visited the specific respondents to make appointments and develop a rapport. The respondents were then visited on the agreed dates and questionnaires administered and collected thereafter completion to ensure high rate of return.

3.7 Data analysis Techniques

Since the study generated both qualitative and quantitative data, organization and analysis took different forms depending on the nature of data. Data obtained was cleaned, verified and presented using tables, frequencies and percentages with the aid of Statistical Package for Social Science (SPSS) and Excel. Content analysis was also employed to analyze qualitative data. Quantitative analysis involved listing and coding open ended data, which together with pre-coded quantitative data were digitalized using the SPSS package and MS Excel. The coded data and quantitative data were then analyzed using descriptive statistics. This involved the use of frequencies, percentages' and means.

The data was summarized and odds ratio (OR) estimated and their corresponding 95% interval (95% CI) were computed. The level of community involvement in healthcare programs was determined using *ad hoc involvement index*. This index was constructed using 6 variables with equal weight in the score:

1. Membership to developmental/healthcare committee

2. Whether the participant has ever attended any stakeholders meeting for any NGO in the community

3. Whether participant was able to list at least three NGOs that work in the community

4. Whether the participant was able to identify a cultural value that affected healthcare programs in the community.

5. Whether participant felt that having healthcare programs in the community was a good thing

6. Whether participant could list challenges in the access of a healthcare program in the community

The involvement score for each respondent could range from 0= no involvement to 6= involved in all 6 activities. A total score of 4-6 was considered as a 'high' involvement score and 0-3 as 'low' relative to the particular population.

Multivariate analysis was performed between involvement index as the dependent variable and other socio-demographic factors as the independent variables.

3.8 Operational definition of variables

Operationalization of variables involves definition of variables in measurable terms. The independent variables of this study will thus be defined as illustrated in table 3.3:

Table 3.3: Operationalization table

Variable	Indicator	Measurable	Scale
Capacity building	-Education forums -Trainings -Health awareness -Membership to a committee or CBO. -Workshops	-Skill (expertise) -Trainings (duration of time) -Existence of health groups.	**Likert Scale.** **-High, low** or **moderate** capacity
Culture	-Medicine or radical practice -Education -Myths	-Myths, practices, cultural values and religious inclinations not in harmony with the program. Myths, practices, cultural values and religious inclinations in harmony with the programs.	**Nominal** **-Positive or Negative** attitude and cultural influence.
Attitude	-Community health interest -Community feelings towards modern medicine.	-People willingness to learn about health programs. -Hospital attendance -Community awareness of health programs in place	**Nominal** -Positive attitude -Negative attitude
Socio-demographic factors	-Education -Age -Occupation -Religion -Gender -Length of stay in the community	Participatory/Involvement Index	**Likert scale**

3.9 Ethical Consideration

Information obtained from other sources or from authors to support the relevance of this research was acknowledged in the form of references. The researcher provided adequate and clear

explanation on the purpose of the study to each respondent. This study protected the rights of participants by asking them to participate voluntarily. No one was coerced into participation. The information obtained from the participants was not made available to anyone who is not involved directly in the study. Participants remained anonymous throughout the study even to the researcher. Research and ethical clearance were obtained from the National Council for Science, Technology and Innovation (NACOSTI).

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents the findings of the research study. Presentation of data, analysis and the discussion of the findings were based on the themes developed from the objectives of the study. The main purpose of this study was to determine the factors influencing community participation in healthcare programs in Siaya County. The results of this study were analyzed using statistical software, namely the SPSS 20.0 computer programme. The information obtained is presented in frequency tables for all variables in order to determine the distribution of variables. Cross tabulation is also done to determine the relationship between the predictor variables and the response. Regression analysis was also used to measure the relative contribution of each of the factors amongst, capacity building, culture and attitude on community participation in healthcare programs in Siaya County. Significance was put at $p < 0.05$.

4.2 Response Rate of Participants

Table 4.1: Response Rate of Participants

	Participants	No.	%
Participants	Respondent	45	84.9
	Non-Respondent	8	15.1
		53	**100**

Fifty three (53) questionnaires were distributed which related to a sample size of 10% of a target population of 267. The response rate was 45(85%), which means 8(15%) of questionnaires were not returned. The questionnaires were administered through drop and pick or by personal administration depending on which method was convenient to the specific respondents. According to Mugenda and Mugenda (2004) a response rate of between 40% to 80% of the total sample size can be generalized to represent the opinion of the entire population. The return rate was considered adequate in providing valid and reliable representation of the targeted population. This high response rate can be attributed to the fact that the research assistants administered the questionnaires and were available to clarify queries as well as prompt respondents to fill in the questionnaires. The response rate for this study was therefore higher than the average rate of academic surveys recommended by experts.

4.3 Demographic Characteristics of Respondents

The respondents were asked to indicate several demographics factors. The information obtained is reflected in this section

4.3.1 Gender of the Participants

The researcher sought to establish the gender of the participants in order to compare the variations in the way different genders would give their opinion on the various components of the study and the results were as shown in Table 4.2

Table 4.2: Distributions of Participants by Gender

	Gender	No.	%
Gender	Male	32	71.1
Participants	Female	13	28.9
		45	**71.1**

Table 4.2 shows that of the 45 participants, 32(71.1%) were males and 13(28.9%) were females. This affirms findings elsewhere that majority of decision making positions are taken up by males and contributes to what objective four of the study is out to investigate.

4.3.2 Age of the Participants

The study sought to establish the age of the participants to identify which gender was represented and at what age set and to reveal the age bracket of the key stakeholders who participate in healthcare programs in the community. The results are as shown in Table 4.3

Table 4.3 Distribution of Participants by Age

Variables					
Gender		**Male**		**Female**	
Participants	**Age in years**	No.	%	No.	%
	26-35 years	9	52.9	8	47.1
	36 – 45 yrs	5	50.0	5	50.0
	Over 45 years	18	100.0	0	0

Table 4.3 shows that among the females, there was no participant above 45 years. Their beginning age bracket ranged from 36 to 45 years of age, these were 5(50%), and 8(47.1%) were between 26 to 35 years of age. Among the males, 18(100%) were above 45 years of age, followed by 9(52.9%) with age range of 26 to 35 years; and 5(50%) male respondents ranged from 36-45 years.

4.3.3 Level of Education of Participants

The level of education was considered crucial for this study. This would help in establishing the influence of education on participation. The respondents were asked to state their education levels and the findings were as summarized in the table 4.5.

Table 4.4: Distributions by Level of Schooling against Gender.

Gender		Male		Female	
Level of schooling	Level of schooling	No.	%	No.	%
participants	University	4	8.9	1	2.2
	College	18	40	4	8.9
	Secondary	9	20	8	15.7
	Primary	1	2.2	0	0
		32	**71.1**	**13**	**28.9**

The findings in Table 4.5 indicates that among the males, most were college graduates 18(40%), followed by secondary school leavers 9(20%), as well as university graduates 4(8.9%). For females, 8(15.7%)) were secondary school leavers, followed by 4(8.9%) college graduates.

4.3.4 Duration of Work in Years

Length of time in the community/institution was considered crucial for this study because it would enable the researcher to evaluate the level of understanding of the respondents regarding the key components of the study and its influence on participatory index. Table 4.5 illustrates the findings

Table 4.5 Duration of Work in Years

Gender	**Male**			**Female**	
Length of time being in the institution or community	**Duration(Years)**	No.	%	No.	%
	Less than 1 Year	14	82.4	3	**17.6**
	1 to 5 Years	15	65.2	8	**34.8**
	11 to 15 Years	3	60.0	2	**40.0**
	6 to 10 Years				
Total		**32**	**71.1**	**13**	**28.9**

It can be observed from Table 4.5 that a significant proportion of the participants 23(45.3%) had been in the institution or community for a period of between 1 to 5 years, 15(65.2%) were male and 8(34.8%) were females. 11 to 15 years were 5 irrespective of gender. Participants who reported to have worked for less than a year were 14(82.4%) males and 3(17.6%) females.

4.3.7 Religious Affiliations of the Participants

The researcher sought to establish the religious affiliations of the participants and the results are as shown in Table 4.6

Table 4.6 Distribution of Gender and Religious Affiliations

Gender	Male			Female	
Religion	**Religion**	No.	%	No.	%
	Catholic	14	82.4	3	17.6
	Protestants	15	65.2	8	34.8
	Muslim	3	60.0	2	40.0
Total		**32**	**71.1**	**13**	**28.9**

There were more male 14(82.4%) Catholics than female 3(17.6), as well as more male Muslim 3(60%) than female 2(40%) and more male protestants than female 15: 8.

4.4 Influence of Capacity building on community participation in healthcare programs

This section sought to present findings in an effort to assess how capacity building as an intervention influence community participation in healthcare programs in Siaya county under the following subthemes; Decision making with regard to implementation of healthcare programs, membership to community development/health committees, perception on adequate representation, contribution of capacity building on involvement/participation and rating of the contribution of various components of capacity building.

4.4.1 Decision making with regard to implementation of healthcare programs

The study can deduce that a composition of members is involved in decision making regarding the implementation of health care programs in the community. This is illustrated in the table 4.9.

Table 4.7 Decision Making with Regard to Implementation of Healthcare Programs in the Community.

Decision Makers	Frequency	Percent
Chief	5	11.1
Assistant Chief	1	2.2
Village Elders	4	8.9
Community Members	19	42.2
CBO Members	12	26.7
Others (Specify)	4	8.9
Total	45	100.0

Table 4.7 shows that a significant proportion of the participants 19 (42.2%) mentioned that community members were involved in decision making with regard to implementation of healthcare programs in the community, 12(26.7%) mentioned CBO members, 5(11.1%) mentioned chiefs, 1(2.2%) mentioned assistant chiefs, and 4(8.9%) mentioned village elders while others who included area ward representatives, pastors and women representatives were classified as the other members accounting to 4(8.9%).

Table 4.8: Decision on Who Participates in Healthcare Training Programs that are implemented in the Community

	Frequency	Percent
NGO Staff	19	42.2
Local Authority	7	15.6
Community Members	8	17.8
CBO members	3	6.7
Don't Know	2	4.4
Others	4	8.9
Medical Department	2	4.4
Total	45	100.0

Table 4.8 indicates that NGO staffs 19(42.2%), are the major decision makers on who participates in healthcare training programs, followed by community members 8(17.8%), local authority follows with 7(15.6%), CBO members 3(6.7%), Medical department 2(4.4%) while another 2(4.4%) have no knowledge on who makes decisions in the committees.

4.4.2 Membership to community development committee

To establish the extent to which community members participate in health/development committees, the researcher first asked the respondents to indicate if they were members of the said committees given that by being a member, an individual would be empowered in decision making through the aspect of collective bargaining

Table 4.9 Whether Participating in Membership of Committees?

	Frequency	Percent
Yes	34	75.6
No	11	24.4
Total	45	100.0

Table 4.9 shows that a significant proportion of the participants 34(75.6%) are members of the community development committee, healthcare committee or the local community based organization, however a proportion of 11(24.4%) are not members of any of the development committee, healthcare committee or CBOs.

For those who are not members, reasons for not being part of the committees was sought and the results are as illustrated in table 4.12

Table 4.10 Reasons for not Joining Community Committee

Views of Participants	Frequency	Percent
Being involved in other activities in the community	16	35.6
There is a perception of the community that committee exploiting them	6	33.3
The committee is an inclusive club of few, they close new members	4	28.9
The approach of committee not participatory	15	13.3
They have neglected real health issues in the community	4	18.9
Total	45	100.0

It can be observed from Table 4.10 that there are various reasons for those who have decided not join any development committee, healthcare committee or CBO, the qualitative analysis shows that the main reason being that there is a general perception in the community that the existing

CBOs, healthcare committee or development committee are not addressing their core mandate and they are seen to be exploiting the community, other reasons as mentioned by the participants was that the so called committees were not participatory and are seen as inclusive clubs for few members and so the committee never open themselves to the community as may be expected, some mentioned that the real health and development issues in the community were neglected, perception of corruption and embezzlement of resources as well as members of community having more pressing socio-economic issues in their lives that they don't find time to attend such committees.

4.4.3 Perception on adequate representation

The study ascertained that a majority of respondents thought that representation in health committees and decision making was inadequate. The reasons the participants gave which could explain the inadequacy of representation of all stakeholders in health committee include lack of coordination of stakeholders which causes the information gap, lack of feedback to and from committee to community, problem of lack of resources, e.g financial where staffs and volunteers have gone for a long time without pay or allowances thus demoralizing them, lack of medicines have also hampered the implementation of the healthcare projects, lack of or poor sensitization, lack of information to the community and poor representation of all stakeholders, cultural and religious factors as well as ignorance among the youth.

Table 4.11 Perception of Community Members on Adequate Representation

Is there adequate representation of members of the committee in the community?

Perception	Frequency	Percent
Yes	18	40.0
No	25	55.6
Don't know	2	4.4
Total	45	100.0

It can be observed from Table 4.11 that a significant proportion of the participants 25(55.6%) feel that there is inadequate representation of all stakeholders in health care committee, 18(40%)

felt that they are adequately represented while 2(4.4%) do not know whether the representation of stakeholders in the healthcare committee as well as development committee is adequate.

The researcher sought to find out the attendance rates of the stakeholders meetings by participants as well as whether their contributions and those of community members are normally incorporated in the subsequent program implementation. the results are tabulated in table 4.12

Table 4.12 Attendance and Implementation of programs

		Frequency	Percent
Attendance of any stakeholder meetings for any NGO	Yes	35	77.8
	No	10	22.2
	Total	45	100.0
Whether participant's contributions are implemented?	Yes	19	42.2
	No	26	57.8
	Total	45	100

It can be observed from Table 4.12 that a significant proportion of the participants 35 (77.8%) attend stakeholders meetings while 10(22.2) have never attended any stakeholder meetings for any NGO in the community. However the same study establishes that most of participants of these stakeholders meetings 26(57.8%) felt that their contributions and those of community members were not incorporated in the subsequent program implementation, never the less a proportion of 19 (42.2%) still believed that their decisions are implemented.

4.4.4 Lists of NGOS that participants were aware of that implement healthcare programs in the community

This section indicates the lists of NGOS that the participants were able to identify as those implementing healthcare programs in the community.

Table 4.13 Lists of NGOS participants are aware of that implements healthcare programs in the community

NGOS	Frequency	Percent
1-3 NGO's	21	46.7
4-5 NGO's	12	26.7
Over 5 NGO's	2	4.4
Total	45	91.1

It can be observed from Table 4.13, that a significant proportion of the participants 48% indicated that there were between 1-3 NGOs operating in the community, 30% mentioned that there were between 4-5 NGOs and 22% mentions that there were over 5 NGOs in the community. NGOs mentioned included; Aphia-Plus, Ace- Africa, Kemri, World vision, Dorcas Foundation, C&C, Red-Cross, UNICEF and Care International.

4.4.5 Influence of the intervention approaches used by stakeholders

The section sought to establish the approaches used by healthcare organizations in implementation of programs, whether handouts or community education on the programs was used.

Table 4.14 Approaches healthcare organizations use in implementing their programs,

	Frequency	Percent
Giving handouts	2	4.4
Educating the community	15	33.3
Both	28	62.2
Total	45	100.0

From the findings, 28(62.2%) of the respondents mention that the health care organizations use both handouts and educating the community, 15(33.3%) of the respondents mention that the healthcare organization use education of the community while 2(5%) indicate that they use handouts

The study findings portrayed mixed reactions as to which were the most preferred approach by the community. Some of the respondents were satisfied with the giving of handouts but a majority of the participants preferred approaches that involved education of the community. This is illustrated in table 4.15

Table 4.15 Preference of participants on the best approaches of implementing healthcare programs

	Frequency	Percent
Educating the community	36	80
Handouts	9	20
Total	45	100.0

Table 4.15 Indicates that most of the participants would prefer educating the community (80%) as the best strategy of implementing healthcare programs in the community, only 20% mention the handouts as the best approach of implementing the healthcare programs.

The study later established that the reasons cited for education being the most preferred approach were as follows; education is important for it help to improve awareness of the existing projects,

education creates ownerships of the existing projects, education improves chances of continuity of the projects, and education creates long-term benefits of the project to the people unlike handouts which is short-term.

4.4.6 Determinants of participation in capacity building programs

A general view of determinants of participation in capacity building programs was also sought and the results are tabulated in table 4.16

Table 4.16 General view of the participants on what determines community participation in healthcare programs

Views of Participants	Frequency	Percent
Their Perceptions about the program	16	35.6
Availability of time	6	13.3
Religious values	4	8.9
Approach used to deliver	15	33.3
Financial capability	4	8.9
Total	45	100.0

It can be observed from Table 4.16 that a significant proportion of the participants 16(35.6%) are of the opinions that perceptions of the community about the benefit of the healthcare programs being implemented is the greatest determinants of participation in capacity building activities relating to a program in the County, followed by the influence of approach used by the project implementer 15(33.3%), third is the availability of time 6(13.3%), and finally financial capability 4 (8.9%) and religious values 4 (8.9%)

4.4.7 Rating of the various components of capacity building

The study sought to rate the role of various training components on capacity building in the implementation of healthcare programs that are implemented in the community and the results are tabulated in table 4.17

Table 4.17 Rating scale of the role of training components on capacity building in the implementation of healthcare programs in the community.

scale of role on capacity building	N	Mean	Std. Deviation
There is adequate representation of all stakeholders in healthcare training programs	45	2.2444	.88306
Community welfare influences healthcare programs in this community	45	3.2889	.72683
Appropriate technology has been used in implementing healthcare programs in the county	45	2.1111	.89499
Health program implementers educate the community on their strategies, objectives and activities	45	3.0667	.83666
Healthcare programs address the health problems with the community	45	3.2222	.67044
Valid N (listwise)	45		

The descriptive statistics including mean and standard deviation is used to analyze the 4 level likert scale with 1= I strongly disagree, 2= somehow/ disagree, 3=somehow agree and 4= strongly agree, the higher the scale the higher the level of agreement with each of the statement, small standard deviation is an indication of dispersion of the opinion of the respondents. The table 4.22 indicates that most of participants somehow agree that community welfare influences healthcare programs in this community (Mean=3.2899, SD=0.72683), The participants similarly

somehow agree that health program implementers do educate the community on their strategies, objectives and activities (Mean=3.0667, SD=0.83666), They also somehow agree that community welfare influences healthcare programs in this community (Mean =3.2289, SD=0.72683). However most of participants somehow disagree that there is adequate representation of all stakeholders in healthcare programs (Mean = 2.244,SD=0.8866) as well as that there is the use of appropriate technology in the implementation of health care programs in the county (Mean= 2.111 SD=0.89499).

4.5 Influence of community culture on community participation in healthcare programs in Siaya County

The study evaluated culture as an influence to program implementation and sought to find out whether healthcare programs implemented in the community were in harmony with the community's way of life. The findings were organized in thematic subheadings as illustrated.

4.5.1 Influence of community culture

The section provides the findings on whether community culture determines community participation in healthcare programs as perceived by the respondents and the findings are as shown in table 4.18

Table 4.18 Community culture as a determinant of community participation in health and development programs

	Frequency	Percent
Yes	39	88.0
No	6	12.0
Total	45	100.0

It can be observed from table 4.18 that a significant proportion of the participants, 39(88.0%) believe that culture is a strong determinant of community participation in health care programs. The qualitative data was analyzed by identifying the main themes from the comments about how exactly culture influence community participation in healthcare programs and identified the following; culture acts as a barrier to implementation of healthcare programs in Siaya County since certain aspects of culture are against hospital attendance, some cultures practiced in the

community could be described as retrogressive and backward for example, wife inheritance which promotes spread of HIV/AIDS, culture, like belief in curses as sources of diseases including HIV/AIDS hamper implementation of healthcare programs. In some regions, people will attend to traditional diviners even when the diseases can easily be cured. The community may also abandon modern medicine for traditional medicine which is associated with high morbidity and mortality of infants because most community members would prefer giving birth at home with the help of traditional midwives. Myths about communicable diseases, sexual aggressiveness of youths associated with culture and beliefs that contraceptives use is a sign of weakness, confounds even vital interventions such as immunization process since some people believe that it is culturally prohibitive. Male circumcision intervention against HIV/AIDs spread being hampered by ignorance because of culture as well.

4.5.2 Community Culture conforming to health care programs

Conformity of cultures to developmental approaches was considered an important determinant of success of health programs. This section provides the findings on the extent to which community culture conforms to the health care programs in Siaya County.

Table 4.19 Extent to which community culture do not conform to health care programs

	Frequency	Percent
To a very large extent	13	28.8
Large Extent	19	42.2
Moderate	13	28.8
Low Extent	2	11.3
Not at all	5	9.6
Total	45	100.0

Table 4.19 shows that most of the respondents accounting to 19 (42.2%) are of the view that the cultural values of the community in Siaya county do not conform to the health care programs offered within the community by large extent. Another significant cross-section accounting to 13(28.8%) mention lack of conformity to a very large extent, 2(11.3%) mention low extent and

5(9.6%) mention no relationship. The explanation for these non conformity of the culture was that a gap of knowledge exist because of the strong cultural myths in the community, being that the community follows a well laid down cultural norms which sometimes may be seen to be contradictory to the modern medicine.

4.5.3 Effect of cultural values on the implementation and participation of the community in healthcare programs

The section also sought to find out views of respondents regarding how cultural values affect the implementation and participation of the community in the health care programs and the findings are as shown in Table 4.20

Table 4.20 Influence of the listed cultural values on the implementation and participation of the community in healthcare programs

	Frequency	Percent
Yes	41	91.1
No	4	8.9
Total	45	100.0

It can be observed from Table 4.20 that a significant proportion of the participants 41(91.1%) are of the view that the listed cultural values affect significantly the implementation and participation of the community in healthcare programs whereas 4(8.9%) are of contrary view.

4.5.4 Community Members Influence in Health care programs

The section indicates the perception of participants regarding influence of the listed cultural values in the implementation of healthcare programs

Table 4.21 Influence of listed cultural values on participation of community members in healthcare programs

	Frequency	Percent
Positive	16	35.6
Negative	29	64.4
Total	45	100.0

Similarly It can be observed from Table 4.21 that a significant proportion of the participants 29(64.41%) are of the view that cultural values affect negatively the implementation and participation of the community in healthcare programs whereas 16 (35.6%) are of contrary view.

4.6 Influence of Community attitude on participation in healthcare programs in Siaya County

It is generally agreed that the target population must have a positive attitude to the program or play a leading role in the selection and implementation of the projects. It was therefore necessary to examine community attitude as a determinant of community participation in health and development programs. This was analyzed and discussed in the following subsequent subheadings.

4.6.1 Views on whether the community has embraced the healthcare programs

This section provides the views on whether the community had embraced the healthcare programs being offered to them and the nature of this embrace ie whether it was negative or positive.

Table 4.22 View on whether the community has embraced the healthcare programs being offered to them positively or negatively

		Frequency	Percent
Valid	Positively	41	91.1
	Negatively	4	8.9
	Total	45	100.0

It can be observed from Table 4.22 that a significant proportion of the participants 41(91.1%) are of the view that the community has embraced the healthcare programs provided or offered to them positively and only 4(9%) understand it as negative

4.6.2 Extent to which community attitude influence healthcare in the community

The section provides the views on extent to which community attitude influence healthcare in this community

Table 4.23 Extent to which community attitude influence healthcare in this community

	Frequency	Percent
To a very large extent	19	42.2
Large Extent	13	28.8
Moderate	5	11.1
Low Extent	3	6.6
Not at all	4	7.2
Total	45	100.0

The responses from most participants in the study was that community attitude towards health care programs influence the healthcare by a very large extent 19(42.2%), by large extent 13(28.8%), by moderate extent 5(11.1%) and by low extent by 3(6.6%).

4.6.3 Opinion on whether the healthcare programs have benefited the community?

The section sought the views of the participants on how they thought healthcare programs had benefitted the community and their responses were as summarized in table 4.24

Table 4.24 Do you think having healthcare programs in the community is good thing?

	Frequency	Percent
Yes	41	91.1
No	4	8.9
Total	45	100.0

It can be observed from Table 4.24 that a significant proportion of the participants 41(91.1%) are of the view that having healthcare programs implemented in the community is a good thing while only 4(8.9%) are of contrary view.

4.6.4 Opinions on the organization of healthcare programs

The section sought the views of the participants on the organization of healthcare programs found within the community. The participants were asked for their perspectives on the organization of the healthcare programs implemented in the community and their views summarized in table 4.25

Table 4.25 Opinion of the participants about the organization of the of healthcare programs

	Frequency	Percent
Average	13	28.9
Good	28	62.2
Very Good	4	8.9
Total	45	100.0

It can be observed from Table 4.25 that a significant proportion of the participants 28(62.2%) are of the view that organization of healthcare programs implemented in the community is good, 13(28.9%) of the participants felt the organization is of average while 4(8.9%) felt the organization is very good.

4.6.5 Challenges facing the implementation of healthcare programs

Another contribution to participation which was studied was the perception of the participants on the challenges facing stakeholders as far as the program implementation is concerned and in healthcare committees as well. The section addresses the challenges facing the implementation of healthcare programs in Siaya county.

Table 4.26 Are there challenges facing the implementation of healthcare program in Siaya County

	Frequency	Percent
Yes	43	95.6
No	2	4.4
Total	45	100.0

Many of the participants accounting to 95.6% acknowledged that there are serious challenges facing the implementation of healthcare programs in the County, only 5% of the respondents mentioned that there are no challenges affecting the implementation of the said programs.

Table 4.27 Key challenges affecting the implementation of healthcare projects

Key challenges	Frequency	Percent
Cultural Issues	19	42.2
Gender Issues	1	2.1
Religious Issues	3	6.7
Issues with Local Authority	1	2.2
Economic Issues	19	42.2
staffing issues	2	4.4
Total	45	100.0

From the respondents the most difficult challenge affecting the implementation of healthcare programs in Siaya county were cultural related issues accounting for 19(42.9%), followed by economic challenges also accounting 19(42.2%), following closely are staffing challenges 2(5%), religious related challenges 3(6.7%), issues with local authority 1(2.2%) and finally gender challenges which is the least of the challenges accounting to 1(2.1%)

The section also sought to establish how the challenges could be addressed and the results were as illustrated in table 4.28.

Table 4.28 Addressing the challenges affecting the implementation of healthcare programs

	Frequency	Percent
Discussion with community	23	51.1
Advice from NGO	11	24.4
Discussion with local authority	7	15.6
Just Ignored	2	4.4
Others Specify	2	4.4

	Frequency	Percent
Discussion with community	23	51.1
Advice from NGO	11	24.4
Discussion with local authority	7	15.6
Just Ignored	2	4.4
Others Specify	2	4.4
Total	45	100.0

It can be observed from table 4.30 that a significant proportion of the participants suggested the following as solutions of the challenges affecting the implementation of health-care programs in the county, 23(51.1%) suggest holding consultative meetings amongst all the stakeholders involved in the health care programs implementation as the key solution to address the challenges, getting advisory from nongovernmental organization on the way to solve the challenges 11(24.4%), holding discussion and consultation with local authority regularly 7(15.6%), involving or encouraging more community participation and owning of the implemented projects (5%), and ignoring the problems and moving on (4%)

4.7 Ranking of capacity building, culture and attitude on influence to participation

The specific objective of the study was to determine the influence of capacity building, culture and attitude on community participation in healthcare programs in Siaya county. The following analysis was done in an attempt to establish the contribution of the variables capacity building, culture and attitude within Siaya county (the unit of analysis)..

Table 4.29 Regression analysis : Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.874[a]	.764	.731	.12225

Adjusted R squared is coefficient of determination which tells us the variation in the dependent variable due to changes in the independent variable, from the findings in the above table the

value of adjusted R squared was 0.731 an indication that there was variation of 73.1% on the capacity building, culture and attitude on community participation in healthcare programs at 95% confidence interval. This shows that 73.1 % changes in community could be accounted for capacity building, mobilization, culture and attitude on community participation in healthcare programs. R is the correlation coefficient which shows the relationship between the study variables, from the findings shown in the table above there was a strong positive relationship between the study variables as shown by 0.874. Coefficients

Table 4.30 Coefficients

Coefficients for capacity building, culture and attitude on community participation in healthcare programs

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	.878	.357		2.459	.016
Capacity Building	.258	.100	.283	1.583	.037
Community Culture	.405	.097	.502	3.145	.001
Community Attitude	.345	.093	.491	1.760	.002

The established regression equation was

$Y = 0.878 + 0.405 X_1 + 0.345 X_2 + 0.258 X_3 + 0.245$ e (an accounted for)

From the above regression equation it was revealed that holding capacity building, culture and attitude on community participation in healthcare programs to a constant zero, addressing culture related issues would lead to an increase of community participation to health care programs at 0.405, a unit increase in improving community attitudes towards health care programs would lead to increase in community participation by a factors of 0.345 and a unit increase in Capacity building along the health care programs would lead to increase in community participation by n by factors of 0.258.Therefore improvement in community participation in healthcare programs in Siaya county will require first addressing deep rooted cultures which seems to be negating any effort to implement the programs, followed by educating community to accept the new lifestyles

and attitudes towards healthcare programs and having done that the other two factors which include capacity building will take over and so the programs may succeed.

4.8 Determinants and levels of Community Involvement in healthcare programs

The level of involvement in healthcare programs was assessed using the variables shown in table 4.31

Table 4.31: Level of involvement of the 45 respondents in Healthcare programs

Item (variable)	Respondents' responses (N(%))	
	Yes	No
1. Membership to development/health committee	34(75.6)	11(24.4)
2. Ever attended any stakeholders meeting for any NGO in the community	35(77.8)	10(22.2)
3. Able to identify cultural values affecting healthcare program implementation in the community	41(91.1)	4(8.9)
4. Able to list at least 3 NGOs that work in the community	45(100)	0(0)
5. Felt that having healthcare programs in the community was A good thing.	41(91.1)	4(8.9)
6. Lists challenges in accessing healthcare services in the Community	43(95.6)	2(4.4)

Table 4.31, shows that only 34 (75.6%) were members of development/or healthcare committee, but most (35 (77.8%) out of 45) had ever attended a stakeholders meeting for any NGO in the community. Majority of respondents 41(91.1%) out of 45 were able to identify cultural values affecting healthcare program implementation in the community. All the respondents 45(100%) were able to list at least 3 NGOs that worked in the community, 41 (91.1%) felt that having healthcare programs in the community was a good thing and a majority 42(95.6%) could list

faced challenges in accessing healthcare services in the community. Only 12 (26%) of the 45 participants had a high participatory/involvement index in all the variables.

Table 4.32 multivariate analysis of association with involvement index (N=45)

Social Demographic Factors	Level of Involvement in Health care Programs						
Gender of the Participants	**Low**		**High**		P value	Odd Ratio	95% C1
	n	%		%			
Male	10	31.31	22	92.3	0.02	5.56	3.65-8.63
Female	1	7.7	12	68.7		2.54	0.54-3.24
	11	**24.4**	**34**	**75.6**			
Age Bracket	**n**	**Low**	**High**		**P Value**	**Odd Ratio**	95% C1
26-35 Years	6	16.7	15	83.3	0.00	**6.56**	4.54-7.24
36-45Years	3	30.0	14	70.0		3.56	3.65-4.63
Above 45 Years	2	28.6	5	71.4		2.23	2.00-3.43
	11	24.4	34	75.6			
	Low		High		**P Value**	**Odd Ratio**	**95% C1**
	n	%	No.	%			
Primary	4	25.0	12	75.0	0.02	2.67	0.54-3.24
Secondary	2	33.3	4	66.7		3.40	3.65-4.63
College	5	22.7	17	77.3		5.23	4.28-6.45
University	0	0	1	100.0		6.20	5.50-7.78

	11	**24.4**	**34**	**75.6**			

	Low		**High**				
Occupation	**%**	**n**	**%**	n	P value	Odd Ratio	**95% C1**
Clinical Officer	0	0	6	100		6.67	5.54-7.24
Nurses	0	0	5	100	0.00	6.40	5.65-6.83
Community Group Leader	5	5	50	100		3.23	2.68-5.45
Assistant Chief	33.3	1	3	67.7		2.20	2.00-2.78
Village Elder	75	15	5	**25**		2.00	1.25-3.03

Experience	**%**	**n**	**%**	**n**	**P value**	**Odd Ratio**	**95% C1**
1-5 Years	31.3	5	68.8	11	0.02	2.67	0.54-3.24
6-10 Years	20.0	1	80.0	4		3.40	3.65-4.63
11-15 Years	10.0	1	90.0	10		5.23	4.28-6.45
Over 15 Years	28.6	4	71.4	14		6.20	5.50-7.78

The variables in the final multivariate logistic regression model were; age, gender, occupation, and length of stay/work in the community (experience). The sample size was 45 respondents (analyzed for involvement/participation index): OR, odds ratio, CI, Confidence Interval.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1Introduction

This chapter is organized into the following subheadings: summary of the study findings, conclusions of the study, recommendations of the study and suggestions for further studies.

5.2 Summary of the findings

The multivariate logistic regression (table 4.32) examined the determinants of community participation in healthcare programs. Complete data was available for all the 45 participants in the logistic regression model. Gender, age, education, occupation and length of stay in the community were included in the logistic regression model as independent variables. The findings indicate that more males(OR= 5.56, 95% C.I= 3.65-8.63) were involved in decision making regarding health care than their females counterparts(OR=2.54, 95% C.I = 0.54-3.24). The difference of gender was statistically significant. At the same time, the community members who were relatively young (26-35) years (OR= 6.56, 95%, CI=4.54-7.24) were found to be more involved in community health care programs than those of the age bracket of (36-45) years (OR= 3.56, 95% CI=3.65-4.63) as well as above 45 years (OR= 2.23, 95%, CI=2.00-3.43). Similarly, participants who had more years in education were more likely to participate in the healthcare programs than those with less education. Those who had attained secondary education or higher were more likely to participate in community health programs than those who had primary or no formal education with the difference being statistically significant as shown in table 4.32 (odds ratios indicating rising participation index with level of education). The community members who had more experience in the community participated more (table 4.32) with participation level being proportionate to the period of being in the community or institution (P=0.02). For example, the odds of being involved in healthcare programs after a 15yr experience (OR=6.20, 95% C.I = 5.50-7.78) was 3 times more as compared with experience of 1-5 years (OR=2.67, 95% C.I = 0.54-3.24) .

In univariate analysis, a high level of involvement was related to capacity building as a result of other secondary variables such as perception of community members about the program (35.6%), approach used to deliver (33.3%) and education on the proposed health program. Descriptive statistics was used to establish the roles of various components of capacity building in the implementation of healthcare programs in the community using standard deviation (Sd) and

mean (m) ($p < 0.05$). Capacity building was found to contribute more when appropriate technology was used (m= 2.111, Sd= 0.89499) and when there was adequate representation of all stakeholders in the process (M= 2.2444, Sd= 0.88306).

Culture was established as a major hindrance to participation with some of the cultural values found to be negating implementation of healthcare programs including wife inheritance which would lead to spread of HIV/AIDs, some practice being barriers to hospital attendance and conventional medicine as well as traditional diviners and medicine men who would make people abandon modern interventions such as contraceptive use, immunization and male circumcision by fueling myths about such modern ways.

Regarding attitude, a significant proportion of the participants 41(91.1%) were of the view that the community had embraced the healthcare programs provided or offered to them positively. However, many of the participants accounting to 95.6% acknowledged that there were serious challenges facing the implementation of healthcare programs in the community with the most difficult challenges relating to attitude and culture (42.9%), economic factors (42,2%), staff issues 2 (5%) and gender related challenges 1 (2/1%). Several factors relating to attitude of the staff working in the facilities were identified as barriers to participation. The first major factor consistently identified by qualitative responses was rudeness and rough handling of clients by health workers in the clinic. A second factor that influenced participation of the community members related to their attitudes towards taking initiatives directed to the health programs, for example, even though a majority reported to belong to health/development committees (75%), 25 (55%) felt that they were inadequately represented by the said committees in decision making because a significant proportion (35.6%) had the views that the approaches used by the committees to reach decisions were not participatory. Others considered other things such as socio-economic factors more important than attending the meetings organized by health committees. The process of decision making was therefore (42.2%) left to NGOs who tried to involve the community through their leaders.

Linear regression was used to determine the influence culture, attitude and capacity building as the independent variables and community participation in healthcare programs as the dependent variables using the coefficients of regression (r) and 95% confidence interval (CI). This was to establish the contribution of the study variables towards community participation in healthcare programs (table 4.30). The findings revealed that holding capacity building, culture and attitude on community participation in healthcare programs to a constant zero, addressing culture related issues would lead to an increase of community participation to health care programs by a factor of 0.405 as compared to addressing attitude whose unit increase will improve community

participation by a factors of 0.345 (table 4.30), and finally a unit increase in Capacity building along the health care programs would lead to increase in community participation by factors of 0.258.

5.3 Discussion of Findings

In this study conducted to establish factors influencing community participation in healthcare programs, it was established that participation was viewed by majority of partners, healthcare workers and even county administrators as a direct link between the community and utilization of healthcare services. This was contrary to what is envisioned by WHO (WHO 2008) of participation not only as a direct link to service utilization but also as a key factor in the context of importance of social determinants of health and health as a human right. The findings also support those by Rifkin (2014) in his article: Examining the links between community participation and health outcomes: a review of literature which reported that in most cases community participation is defined as the intervention seeking to identify a direct causal link between participation and improved health status.

Level of participation was an outcome measured by means of ad-hoc variables within the questionnaire and its strength of association with significant socio-demographic factors measured using odds ratios. Despite level of participation being high with certain variables such as education, there was little evidence linking participation with health outcomes. This affirms a study by Rifkin (2009) which showed similar results. It also negates the growing interest on public participation within the county governments.

In the study, a number of factors associated with community participation in healthcare programs were found. This included socio-economic, health system and cultural variables. First, socio-economic factors were a challenge with 19 participants (42.2%) mentioning this as the case. Some mentioned that they had more economic issues pressing them in their lives that they did not find time to even attend healthcare committees. Similar constraints have been found in Dodoma, Tanzania (Cartoux et al, 1998). In addition, the level of education and occupation of the respondents were found to influence participation in healthcare programs. Similar studies in Uganda and elsewhere have found that education level is an important determinant of participation in Prevention of Mother to Child Transmission of HIV (PMTCT) services (Layatuu et al, 2008).

Other factors that were a challenge to participation were related to the health system. There was the perception of corruption and embezzlement of resources as well as a general perception in the community that the existing CBOs, healthcare and development committees were not addressing their core mandate and were seen to be exploiting the community besides being inclusive clubs of a few members. This findings affirms those by Kenya Anti-Corruption Commission report on corruption in healthcare (2010) which reported that corruption had increased the cost of healthcare and undermined the government's efforts to provide adequate accessible and quality healthcare. The report outlined the anatomy of corruption which included fraudulent procurement of drugs, and medical supplies which resulted in overpricing and procurement of substandard goods and supplies, outright theft of drugs and medical supplies by public officials responsible for their custody and administration, unofficial payments (bribes) by patients to enable them access or speed up service delivery and increased cost of care just to mention but a few. It also concurs with findings elsewhere that the failures encountered in attempts to forge genuine participation within the community are related to those charged with task not being in a position provide it.

Cultural factors were found to be a barrier to participation. For example, certain aspects of culture were found to be against hospital attendance while others hampered implementation of health programs like seeking the services of traditional medicine men. In the study, 19(42.2%) of respondents were of the view that the cultural values of the community were not in conformity with certain healthcare programs to a large extent. The explanation for this was that the community follows a well laid down cultural norms which sometimes maybe seen to be contradictory to modern medicine. Similar findings were made by Mwandi et al (2011) in the implementation of Voluntary Medical Male Circumcision (VMMC) program in Western Kenya.

The strengths of the study is that those who play a leading role in program implementation were interviewed. The information obtained is likely to reflect the leaders views other than the views of end consumers of the services. Qualitative and quantitative methods were used during data collection. The qualitative findings assisted in explaining the findings from the quantitative part of the study. However, there were some potential weaknesses in the methodology. First, the recruitment of respondents could have introduced selection bias given that only leaders were involved. Second, the participation/involvement index has not been used before and its validity and reliability have not been established in the unit of analysis. Through literature review, no established instrument was found to assess community participation and there were challenges in the definition of community and participation.

5.4 Conclusions of the study

Structural and cultural barriers to community involvement in healthcare programs in Siaya county were complex and interrelated. Community sensitization about the benefits of health programs should be prioritized in order to improve community participation and mitigate the effect of socio-economic and cultural barriers. Addressing cultural barriers and attitude will increase the contribution factors such as education and capacity building. Similarly the role of health care organization was established whereby community demanded community friendly clinics where the patients feel comfortable obtaining health services. However, community engagement and uptake of intervention services is critical so that the community will feel owning the initiative and bring more acceptances of the programs. Another conclusion is that in order to catalyze behavioral changes at a societal scale, health education programs must address the cultural and social dimensions of health care. This means that healthcare necessities will not be used unless accompanied by effective and culturally appropriate education. The need to build an environment of trust through working with a different cultural and social context, it is necessary to engage with a community .Culturally appropriate education should be tailored and framed from the perspective of the target community. Thus, to develop a culturally relevant education program, one must engage strategically with local culture to look at the way in which culture influences lifestyle and behavior. Many participants also advocated for changing community attitude towards implementing a healthcare education initiative which remove barriers towards acceptance of the initiative is important

5.4 Recommendations of the study

From the findings, discussion and conclusions of the study in line with the objectives, the following recommendations were made

1. There is a need to improve on the capacity building of community in order to make the people gain control of the program and decisions that shape their health care. The study also observed that the composition of different stakeholders who includes the representative local administrators including area chiefs, assistant chiefs, ward representatives, board members, local government, NGO staffs, clinical officers, nurses, women representatives, youths, clergy, opinion leaders need to be improved to make the community own the programs being implemented

2. It can be observed that a significant proportion of the participants believe that culture is a strong barrier to community participation in health care programs. Therefore due concerns need to be done to understand the community culture to improve the outcomes
3. One way to ensure that education efforts are culturally appropriate is to develop programs that are locally led and managed by local healthcare professionals, supported and assisted by community health workers.

5.5 Suggestions for Further Study

1. Expanding this study to other regions in the country where the same barriers exist in implementation community based health programs and therefore encouraging more community participation
2. Comparative study of the study to compare the findings of the current study in urban areas, Expanding this study to other regions in the country where the same barriers exist in implementation community based health programs and therefore encouraging more community participation
3. Changing the methodology of the study to includes sentiments of all stakeholders other than the implementers of the projects and opinion leaders..

REFERENCES

Airhihenbuwa, C.O. (2005). Health and culture beyond the western paradigm. Thousand Oaks (CA). Sage publication.

Abdulraheem, I.S., Onajole, A.T., Jimoh, A.A.G., and Oladipo, A.R. (2011). Reasons for incomplete vaccination and factors for missed opportunities among rural Nigerian children. *Journal of Public Health Epidemiology* vol. 3(4), pp. 194-203

Atkinson, J., Vallely, A., Fitzgerald, L., Whittaker, M. (2011). The architecture and effect of Participation; a systematic review of community participation for communicable disease Control and elimination. Implications for malaria elimination. Malaria journal 10: 255

Baum, F. (2008). Foreword to Health promotion in action from local to global Empowerment.

Bracht, N., Kingsbury, L. (2000). Community organization principles in health Promotion: a five stage model. Health promotion at the community level Newbury Park (CA). Sage publications.

Best J.W., and Khan J.V. (1988). Research in Education (8th ed). Boston Allgin and Bacon.

Braithwaite R.L., Bianchi C., Taylor S.E. (2004). Ethnographic approach to community organization and health empowerment. Health Education Quarterly.

Butterfoss, F.D., Goodman RM., Wandersman, A. (2003). Community coalitions for prevention and health promotion. Health Education Research.

Chang, M.A., Condon, N.G., Baker, S.K., Bloem, M.W., Savage, H. and Sommer, A. (2008). The Surgical Management of cataract: barriers, best practices and outcomes. *International ophthalmology*.

Chavis, DM., Wandersman, A. (2000). Sense of community in the urban environment: a catalyst for participation and community development. *American journal of community psychology*.

Cohen, L.M.; McChargue, D.E.; & Collins, Jr. F.L. (Eds.) (2003). The health psychology

handbook: Practical issues for the behavioral medicine specialist.
Thousand Oaks (CA). Sage publications.

Conway T., Moser C., Norton A. and Farrington, J. (2002), Rights and livelihoods approaches: Exploring policy dimensions, Natural resource perspectives. *London Overseas development Institute*.

Coreil, J., Augustine, A., Holt, E., & Hasley, M.A. (1989). Use of ethnographic research for instrument development in a case control study of immunization in Haiti. *International Journal of Epidemiology*; 18; 33-37.

Cote S.,Morgan L.M. (2002). A longitudinal analysis of the association between emotion regulation, job satisfaction, and intentions to quit. *Journal of Organizational Behavior* vol 23, 947–962

Edward, O. (2006). A Practical Guide to Global Health Service. *American Medical Association*.

Fawcett S.B., Paine-Andrews, A., Francisco, V.T., Schultz, J.A., Richter, K.P., Lewis, R.K., William E.L., Harris K.J., Berkley J.Y.., Fisher J.L, Lopez C.M. (2005). Using Empowerment theory in collaborative partnership for community health and development. *American Journal of Community Psychology*.

Florin P., Wandersman, A. (2000). An introduction to citizen participation, voluntary organizations, and community development: insights for empowerment through research. *American Journal of Community Psychology*.

Gay, L.R. (2003). Educational Research. Competencies for analysis and applications. Upper Saddle River, NJ: Merrill Prentice Hall

Goodman, R. M. (2000) Evaluation of community based health programs: an alternate perspective and Integrating Behavioral and Social Sciences with Public Health. *American Psychological Association Press,* Washington DC.

Goodman, R.M., Steckler A.B. (2006). The life and death of a health promotion program:

an institutionalization case study. International Quarterly of Community Health Education.

Goodman R.M., Wandersman, A., Chinman, M., Imm P., Morrissey, E. (2008).
An ecological assessment of community-based interventions for prevention and health promotion: approaches to measuring community coalitions. *American Journal of Community Psychology*. Jossey Bass Publishers.

Harris, D et al., (eds) (2005), The Inter-American System of Human Rights 289. *Oxford Claredon Press*.

Haggstrom., E. (2010). "Slums Find Dignity In Sanitation,". ICOSA Magazine,

Hausermann, J. (2003). A human rights approach to development. London: Rights and Humanity.

Henderson, B A., Kim., J.Y., Ament, C.S., Ferrufino-Ponce, Z.K., Grabowska, A., and Cremers S.L. (2007). "Clinical idiopathic cystoids macular edema. Risk Factors for development and duration after treatment". *Journal of Cataract and Refractive Surgery*.

Holden, B.A. (2007). "Blindness and Poverty*:* A Tragic Combination." Clinical and Experimental optometry.

Housman, J., Dorman, S. (2011). The Alameda County Study*:* A Systematic, Chronological Review. *American Journal of Health*.

Jadad A.R., & O'Grady, L. (2008). "How health should be defined*?*

Kirigia et al., (2011). Effects of maternal mortality on gross domestic product (GDP) in the WHO African region.

Kothari, C.R. (2005). Research Methods and Techniques (2nd ed): New Delhi.

Kenya National Bureau of Statistics (KNBS) and ICF Macro. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS & ICF Macro. 2010. Google Scholar.

Kenya Anti-Corruption Commission Report (2010): The Economics of Corruption

Labonté R., & Laverack, G. (2008). Health promotion in action from local to global

empowerment.

Lander, D.A., & Graham-Pole, J.R. (2008). Love medicine for the dying and their care givers, the body of evidence. *Journal of Health Psychology*.

Lancet, (2008). Alma-Ata 30 years on: Health for all need not to be a dream buried in the Past: 372-917-1002.

Laverack G., Wallerstain, N. (2001). Measuring Community Empowerment*:* a fresh look at organizational domains. Health Promotion International (16: 179-185)

Laverack, G. (2004). Health Promotion Practice: Power and Empowerment. London. Sage.

Malcolm, G. (2005). Blink: The power of thinking without thinking. BackBay Books.

Ochako et al., (2011). Utilization of maternal health services among young women in Kenya: Insights from the Kenya Demographic and Health Survey.

Ogden, J. (2007). Health psychology, 4th edition, Berkshire, England: Open University Press.

Olujide, M.G. (2008). Attitude of Youth towards Rural Development Project in Lagos Estate Nigeria. University of Ibadan, Nigeria. Journal of Social Science 17 (2): 163-167.

Mugenda & Mugenda. (2008). Social Science Research: Theory and principles. Nairobi Arts Press.

Pattanayak et. al., (2009). "Shame or subsidy revisited: social mobilization for sanitation in Orissa, India*."* Bull World Health Organ, vol. 87, no. 8

Putnam, R.D. (2005). Bowling alone: America's declining social capital. Journal of Democracy.

People's Health Assembly (2000). Peoples Charter for Health. People's Health Movement. Retrieved from http://www.phmovement.org/files/phm-pch-english. pdf

Quick, J.C.; & Tetrick, L.E. (Eds.). (2003). Handbook of occupational health psychology. Washington, DC: *American Psychological Association*.

Rifkin, S.B. (2009). Lessons from Community Participation in Health Programs. A review of Post Alma Ata experience. International Health 1: 31-6

Sarkar, S. (2010). "Community engagement in HIV prevention in Asia*:* going from 'for the community' to 'by the community' must we wait for more evidence?" Sexually Transmitted Infections, vol. 86, no. 1.

Saunders, Lewis and Thornhill. (2009). Research methods for business students, 5th Edition. Prentice hall.

Thomas, Stephen B., Michael J. Fine, and Said A. Ibrahim. (2004)."Health Disparities: The Importance of Culture and Health Communication." Am J Public health.

Thompson, B., & Kinne, S. (1990). Social change theory: applications to community health. Health promotion at the community level, Newbury Park (CA), Sage Publications.

Waisbord, S. (2005). Five key ideas, coincidences and challenges in development communication and global change Rethinking Communication for Development. Nordicom and CLASCO

WHO report (2008)

WHO report (2006)

WHO report (2004)

WHO report (2000)

Ware et al., (2009). Explaining Adherence Success in Sub-Saharan Africa: An Ethnographic Study. PLoS Medicine.

APPENDICES

APPENDIX A: LETTER OF TRANSMITTAL

University of Nairobi,

Department of Extra-Mural Studies,

P.O Box 30197,

Nairobi.

July 2013.

Dear Sir/Madam,

RE: LETTER OF TRANSMITTAL OF DATA COLLECTION INSTRUMENTS

May I take this opportunity to inform you that I am undertaking a research study leading to a Master of Arts degree in Project Planning and Management of the University of Nairobi. The study focuses on influencing factors on community participation in healthcare programs in Siaya county.

When the study is completed, the findings will enable the community develop in terms of healthcare by equipping primary stakeholders, program managers and leaders with the necessary knowledge to open up new perspectives on public policies that may help in health promotion within the community. Your input is therefore very important and will define the success of this study.

Attached please find a questionnaire that requires you to provide information by answering questions honestly and objectively. You are not required to record your name anywhere and the information provided will be treated with outmost confidentiality.

EDWARD OMONDI OCHIENG

RESEARCHER.

APPENDIX B: QUESTIONNAIRE

This questionnaire has been designed to collect information on the influence of community participation on healthcare programs in Siaya. The information gathered will be used purely for the purpose of academic research and will be treated with utmost confidence. Please feel free and provide frank and honest answers without fearing prosecution or disclosure. The researcher will only look at the collective feedback of ALL the respondents.

Instructions

1. Tick appropriately in the box (☐), circle appropriate answer or fill in the space provided.

2. Feel free to give further relevant information to the research and not in the questionnaire.

PART A: RESPONDENT'S PROFILE (Please tick appropriately)

1. Please record your sex.

   1. Male ☐
   2. Female ☐

2. How old are you? …………………… (Record your age in number of years)

3. Are you able to read and write in English and Kiswahili or any other local language?

   1. Yes ☐
   2. No ☐

4. Have you ever attended school to acquire education?

   1. Yes ☐
   2. No ☐

5. If YES, what is the highest level of schooling that you completed?

☐ Secondary ☐ University ☐ College ☐ Primary

6. What is your religion?

   1. Christian catholic 2. Christian protestant
   3. Muslim 4. Other (specify)……………

7. Position held in the institution or community.

☐ Clinical officer ☐ Nurse ☐ Community group leader
☐ Assistant chief ☐ Village elder
Others, specify………………………………………

8. How long have you been in this institution or community?

☐ Less than 1 year ☐ 11 to 15 years

☐ 1 to 5 years ☐ 6 to 10 years others, (specify)………………

PART B: CAPACITY BUILDING

9. Who are involved in decision making with regard to implementation of healthcare programs in this community?

1. Chief 2. Assistant chief 3. Village elders

4. Community members 5. CBOs members. 6. Others (specify)………………….

10. In this community, who constitute development committee? (State the position held or title of the individual)

……………………………………………………………………………………………………
……………………………………………………………………………………………………

11. Are you a member of any development committee, healthcare committee or CBO?

1. Yes

2. No

12. If No in question 7 above, why are you not a member?

Please state:

……………………………………………………………………………………………………
……………………………………………………………………………………………………

……………………………………………………………………………………………………

13. Do you think there is adequate representation of all stakeholders in healthcare committee/District health Committee?

1. Yes

2. No

3. Don't know

If No, please explain why

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

14. Who decides on who participates in healthcare programs that are implemented in the community?

1. NGO staff 2. Local authority

3. Community members 4. CBO members

5. Don't know 6. Others (specify)…………..

15. Have you ever attended any stakeholders meeting for any NGO in this community?

1. Yes

2. No

16. If YES in question 16 above were your contributions and those of community members incorporated in the subsequent program implementation?

1. Yes

2. No

17. In your view generally what determines community participation in healthcare programs?

1. Their perceptions about the program 2. Their cultural values

3. Availability of time 4. Influence of local authority

5. Religious values 6. Approach used to deliver

7. Financial capability

18. Does the local authority contribute in any way to program implementation in this community?

1. Yes

2. No

19. In what way do they contribute?

1. Mobilization 2. Security 3. Sensitization

4. Participation in health committee meetings

5. Providing venues for program activities.

6. Others specify…………………………………………………………………………..

20. On a scale of **1-4,** with **1= I strongly disagree; 2= somehow disagree; 3= somehow agree; 4= strongly agree**. Please rate the following statements.

Statements	**Score/4**
1. There is adequate representation of all stakeholders in healthcare programs.	☐
2. Community welfare influences healthcare programs in this community.	☐
3. Appropriate technology has been used in implementing healthcare programs in the district.	☐
4. Health program implementers educate the community on their strategies, objectives and activities	☐
5. Healthcare programs address the health problems with the community.	☐

21. Does mobilization/campaigns influence participation in healthcare in this community?

☐ Yes
☐ No

Please explain
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

22. How many NGOs are you aware of that implement healthcare programs in this area?
……………………………………………………………………………………………………
……………………………………………………………………………………………………

23. List the NGOs you know that work in this community.
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

24. What approach do the healthcare organizations use in implementing their programs, do they give handouts based on need or do they educate the community on their programs?

1. They give handouts
2. They educate the community
3. Both

25. In your opinion, which of the two approaches do you prefer?

1. Giving hand outs.
2. Educating the community

Please explain:
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

PART C: COMMUNITY CULTURE

28. Are you aware of the cultures of this community as a member or a healthcare provider?

1. Yes ☐
2. No ☐

29. Do you think that healthcare programs offered within the community are in harmony with the community way of life (in terms of religion and cultural values?)

☐ To a very large extent ☐ large extent ☐ Moderate ☐ Low extent ☐ not at all

Please explain?

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

30. What are some of the cultural values and religious inclinations that are not in line with the healthcare programs being offered?

Please state clearly

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

31. In your view do these cultural values listed above affect the implementation and participation of the community in healthcare programs in the community?

1. Yes ☐
2. No ☐

32. How do they influence participation of community members in healthcare programs?

1. Positively

2. Negatively

Please explain

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

33. What do you think can be done to enhance participation in healthcare programs in your community while also taking care not to disregard the community's values and beliefs?

Please state clearly

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

PART D: COMMUNITY ATTITUDE

34. In your view how has the community embraced the healthcare programs being offered to them?

1. Positively

2. Negatively

35. To what extent does community attitude influence healthcare in this community?

☐ To a very large extent ☐ large extent ☐ Moderate ☐ Low extent ☐ Not at all

Please explain…………………………………………………………………...............................

……………………………………………………………………………………………

36. Do you think having healthcare programs in the community is a good thing?

( ) Yes ( ) No

Briefly explain

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

37. What do you think about the organization of healthcare programs in the community?

( ) Poor ( ) Average ( ) Good ( ) Very good ( ) Don't know

38. Do you face challenges in healthcare program implementation?

1. Yes
2. No

39. What are some of the challenges?

1. Cultural issues
2. Gender issues
3. Religious issues `
4. Issues with local authority
5. Economic issues
6. Others, specify………………………………….

40. How have you handled these challenges?

1. Discussion with community
2. Advice from NGO
3. Discussion with local authority
4. Just ignored
5. Others, specify……………………………………………………………………….

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Thank you