THE INFLUENCE OF CHALLENGES FACING COMMUNITY HEALTH WORKERS IN THEIR COPING STRATEGIES WITH VULNERABLE CHILDCARE IN KAKAMEGA

Opimbi, O. A., Kathuri-Ogola, L., & Muriithi, J. K.

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THE INFLUENCE OF CHALLENGES FACING COMMUNITY HEALTH WORKERS IN THEIR COPING STRATEGIES WITH VULNERABLE CHILDCARE IN KAKAMEGA

[1] Opimbi, O. A., [2] Kathuri-Ogola, L., & [3] Muriithi, J. K.

[1] Msc. Student, Department of Population, Reproductive Health and Community Resource Management, Kenyatta University [KU], Kenya

[2,3] Doctor, Lecturer, Department of Population, Reproductive Health and Community Resource Management, Kenyatta University [KU], Kenya

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ABSTRACT

The purpose of this study was to investigate the influence of challenges facing community health workers in their coping strategies with vulnerable childcare in kakamega. A cross-sectional survey design was used to describe the opinions of a proportionate sample of 191 Community Health Workers from different Faith/Community Based Organizations. Six program coordinators of Catholic Relief Services Mwendo (CRSM) purposively sampled were also included in the study. Pretested interview schedules and KI guides were used for data collection. Cronbach coefficient Alpha was used to assess internal consistencies of items in the tools. Qualitative data was analyzed by content and thematic analysis. The findings revealed that almost all the participants faced challenges in their line of duty. However, supervision and training did not influence the coping strategies they adopted while workload, stock outs of tools and materials and inadequate funds negatively influenced the coping strategies. Community Health Workers who faced the challenges of workload used coping strategies such as emotion focused and avoidant and vice versa. The study recommended that guiding and counseling centers to be established by the organizations for Community Health Workers with challenges to get relevant help. National governments and donors should strongly invest in integrated Community Health Workers programs to enable equitable, efficient and effective use of the existing funding. Advocacy is needed at the County government level, to promote financial investment in Community Health and integrated service delivery.

Key Words: *Community Health Workers Challenges, Coping Strategies*

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INTRODUCTION

Community Health Workers (CHWs) are volunteers who assist Vulnerable Children (VC) in underserved communities, to access Primary Health Care (PHC) and social services, by linking them to health and social service systems (Oliver, Giniets, Winters, Rega. & Mbae, 2015). They increase health education through workshops and door-to-door outreach programs. They also provide informal counseling, referrals, social support and advocacy for the vulnerable children (American Public Health Association, 2009). Therefore, they bolster healthcare teams and improve the quality of life for the vulnerable children, leading to improved health outcomes, reduced health disparities and social justice (Rosenthal *et al*., 2017).

In Kenya, the roles of Community Health Workers have changed overtime. From distributing family planning products, to educating people on the prevention and management of communicable diseases and the importance of clean water/sanitation. They also provide social services to the vulnerable such as Vulnerable Children. Hence, they are referred to as Village Health Volunteers (Adam *et al.*, 2014).

The Community Health Workers (CHWs) have nonetheless had constraints such as lack of facilitation in movement, poverty, delayed payment of stipend, overworking and incomplete CHW' kits. This in turn slowed down their productivity and efficiency (Nzioki, Onyango & Ombaka, 2015). They consequently had to adopt coping strategies such as problem focused, emotion focused and/or avoidance coping strategies in order to navigate through their challenges. In spite of this, gaps still exist in their performance which in turn affects health outcomes (Sarin & Lunsford, 2017).

Problem Statement

Community Health Workers (CHWs) contribute to community health by providing Primary Health Care and social services to the Vulnerable Children (Kisia, Nehemia, Odhiambo,Wamalwa & Salim, 2012). Their performance is based on their job satisfaction (Gopalan, Satayanaraya, & Ashis, 2012). They however encounter numerous challenges while on duty which limit their productivity and lead to their attrition.

Programs that rely on volunteer Community Health Workers (CHWs) experience high attrition rates ranging from 3.2% to 77%. In Kakamega, Kenya, there was a 33% attrition rate in 2010 in Home Based Care programs (Olang'o, Nyamongo & Hanse, 2010). Moreover, CHWs mostly adopt negative coping strategies like emotion focused and avoidance coping, which may not as such improve their performance and wellbeing (Aridi, Champman, Wagan, & Negin, 2014; Pandey & Singh, 2015).

In an effort to understand and contribute to a solution to the high Community Health Worker (CHW) turnover from community health programs, the study analyzed the influence of challenges facing community health workers in their coping strategies with vulnerable childcare in kakamega.

Objective of the Study

The study investigated the challenges and coping strategies faced by Community Health Workers engaged in Organizations supporting Vulnerable Children in Kakamega County. The specific objectives were;

- To identify challenges facing community health workers engaged in organizations supporting vulnerable childcare in Kakamega County
- To determine the influence of the challenges faced on coping strategies adopted by community health workers engaged in organizations supporting vulnerable children in kakamega county

The study was guided by the following hypothesis;

H_0: There is no significant relationship between the challenges faced and the coping strategies adopted by community health workers engaged in organizations supporting vulnerable children in Kakamega County.

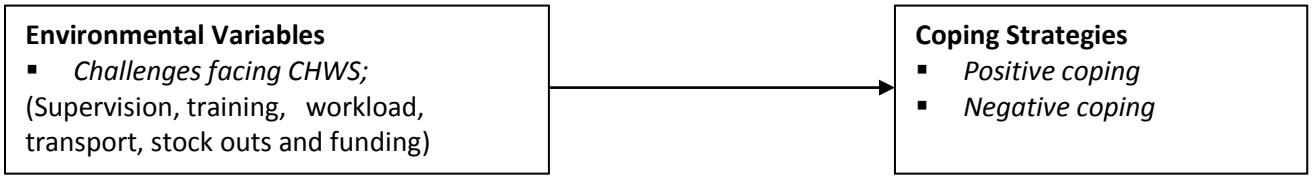

Figure 1: Conceptual Framework

LITERATURE REVIEW

Challenges facing Community Health Workers

The sustainability of Community Health Worker' programs depended on their ability to cope with the obstacles on the ground. This in turn relied on their training, their workload, supportive supervision and reliable funding, (CHW toolkit, 2011). A study conducted by Aridi, *et al.,* (2014) in rural Kenya, found out that Community Health Workers programs had provided poor quality services due to the numerous challenges faced.

Unsupportive Supervision to Community Health Workers: According to a study conducted in Philippines, Supervision of Community Health Workers (CHWs) was often of poor quality if present at all, and it often was done by their peers. In Mozambique, it was mostly an irregular and infrequent inspection carried out periodically, without feedback (Hill *et al*., 2014; Ndima *et al*., 2015).

In Malawi, Community Health Worker (CHW) supervision concentrated on fault finding and hence it was seen as unsupportive. This was due to lack of the necessary resources, which in turn made the training of the supervisors to be difficult, (Bradley, 2013). This in effective supervision led to low CHW morale and this made it more difficult to cope with the obstacles on the ground, (Jaskiewicz & Tulenko, 2012).

Indeed, supervision contributes to quality of Community Health Workers' work. In Kenya for instance, CHW's supervisory relationship was a particular important feature in their accounts, in assuring and enhancing the quality of their work (Oliver et al., 2015).

Community Health Workers' Training and Certification: The lack of a standard core curriculum for training and certification led to Community Health Workers (CHWs) receiving on-the job training, which was intended for a specific program. This equipped them with the skills required for only that specific project (APHA, 2009). CHWs in India had limited orientation because their training was done by themselves or coworkers (peer training) and this disadvantaged them on coping with the obstacles on the ground, (Sharma, Webster & Bhattacharya, 2014). According to Kane et al., (2016), in Bangladesh, Indonesia and Mozambique, all CHW programs involved competence based trainings of specific tasks, which were targeted at specific situations. Furthermore, the training were supplemented by practice sessions and on-the-job training.

A study conducted in South Africa by Sibeko *et al.,* (2018) showed that 97% of the Community Health Workers underwent a mental training program with 63% of them demonstrating an improvement in knowledge, confidence, change in attitude and benevolence. However, in an earlier study by White et al., (2017) still in South Africa, 7% of CHWs considered their training as average which did not impart the skills required to perform their duties.

In 2015, Kaseje found out that the current Community Health Worker (CHW) training programs in Kenya just provided single interventions and capacity building interventions, which relied on the available funding and focused on the founder's priorities. Additionally, there was informal training, which varied in content, mode of delivery, duration and lacked accreditation. According to a case study conducted in Kenya by

Oliver *et al.,* (2015), the quality of CHW training varied depending on when it was done and who trained them. It focused on abstract issues instead of practical issues. Moreover, CHW programs provided in-service training, continuous training and/or refresher courses, these improved their effectiveness in their work. However, this was in some instances done haphazardly and they therefore expressed the need for more training.

Unmanageable Workload for Community Health Workers: Workload played a defining role in the level of productivity and quality of work of Community Health Workers. Workload can be described by the number and organization of tasks and the catchment area. The catchment area includes two aspects: the number of households to be served and their geographic distribution. All these subcomponents must be considered in ensuring a realistic workload for CHWs (Jaskiewicz & Tulenko, 2012).

A study conducted by (Singh &Sachs, 2013) found high work load to be a setback to the performance of Community Health Workers (CHWs) in Sub Saharan Africa. The CHW to population ratio was 1:4074 which was seven times more than the recommended ratio of 1:500. Even recent programs in Sub Saharan Africa still had 1;2400 CHW to population ratio which was considerably too high (Gichaga, Masis, Chandra, Palazuelos &Wakaba, 2021).

Community Health Workers (CHWs) needed manageable workload in terms of realistic number of tasks, a smaller population of clients and a reasonable geographic distance to cover Jaskiewicz & Tulenko, (2012). However, this was not the case because of task shifting and lack of clarity on their tasks and roles. This high work load lowered their motivation levels, and led to poor performance since they were unable to cope with the obstacles on the ground (Kok, *et al*., 2015).

Transport for Community Health Workers: Community Health Workers in Rural Haiti experienced transport challenges. They had to travel to the rural areas where some roads were unsafe and impassable, due to unfavorable weather and poor geographical terrain. Hence, they used non-motorized transport forms like camels, and boats (Jerome & Ivers, 2010) Those in Rural Sao Paulo passed through fences to access homes which were also sparsely distributed and thus, they had a large geographical region to cover, (Baptistini & Figuelredo, 2014).

Community Health workers in Ethiopia, Malawai and Rwanda lacked gumboots and umbrellas which made their work even more difficult (Chandani *et al.*, 2014). Where as in Uganda, according to Brunie, *et al.*, (2014), they experienced limited access to transportation in addition to having insufficient transport refund, yet they had to hire a 'bodaboda' which saved energy and time but it was expensive.

Community Health Workers in Kenya faced the challenge of transport as a recurrent issue. They walked, carried patients on stretchers, improvised transport or sometimes paid fare. This limited their referral work and their ability to visit remote homes. At times they used manpower and wheelbarrows with mattresses which they called 'community ambulance' to take clients to the referred health center. These issues complicated their work immensely (Oliver *et al*., (2015). Less than a quarter (19%) of CHWs in Kisumu used of motorbike and even bicycles for transportation (Aseyo et al., 2018).

Stock Outs for Community Health Workers: Community Health Workers (CHWs) in South Africa complained of inconsistent and inadequate supply of masks and gloves, which made their work difficult (White et al., 2017). Jaskiewics & Tulenko (2012) also emphasized the fact that without regular restocking of supplies and equipment, CHWs could not carry out their tasks effectively, hence they lost the community's trust and respect. In Uganda, inconsistent supply of commodities made it difficult for them to complete their tasks (Brunie *et al*., 2014).

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According to Oliver *et al*., (2015), insufficient materials to cope with the obstacles on the ground were a major challenge to Community Health Workers (CHWs) in Kenya. This was especially experienced by those linked to Non-Government Organization (NGO) sponsored programs. CHWs in Kisumu Kenya complained of infrequent provision of supplies and materials for their work. Organization did not sufficiently supply gloves, gumboots and first aid kits which reduced the extent to which they would intervene in local households, constrained their opportunities to deliver health care and placed them at personal risk. This consequently affected their coping and their relationship with the communities that they served (Aseyo et al., 2018).

Insufficient Funding for Community Health Workers' programs: Fair wages were necessary to the Community Health Workers (CHWs) in the United States, to ensure security of their livelihoods and commitment to service delivery (Watt *et al*., 2011). Additionally, they had a right to financial compensation (Farmer, 2010). The CHWs in Nepal received dismal compensation. The programs that relied on CHWs had unsustainable and unreliable funding which increased their attrition, since they were dissatisfied with their financial compensation in relation to the invested time, (Glenton, Scheel & Pradhan, 2010).

In Sub-Saharan Africa, Community Health worker (CHW) programs were high value investment in health, since the annual cost per capita served was comparatively low. However, these programs were underfunded due to lack of political prioritization, presence of unsupportive policies, strategies and investment case documents, in effective and fragmented donor funding structure and suboptimal impact of the CHW programs (Gichaga et al., 2021).

According to the Community Health workers (CHWs) in Kenya, the challenge of stock out of materials, transport, unsupportive supervision and inadequate training, all arose from the challenge of insufficient and unreliable funding, Oliver *et al*., (2015). CHWs in Kisumu Kenya, did not receive any form of stipend from the government but instead they got some from Non-Governmental Organizations. This stipend at times delayed and it ranged from 8,000Ksh. to 1,600Ksh. They mentioned that it was difficult to devote to their work without any government allowances (Aseyo et al., 2018).

Coping Strategies adopted by Community Health Workers

Coping occurs when an individual changes behavioral or cognitive efforts to meet inner or outer demands. Coping can be positive coping (problem focused) or negative coping (emotion focused and avoidance coping strategies), Baqutayan, (2015).

Problem-focused Coping Strategy/ Task oriented: This was when efforts were directed to reducing or eliminating the stressor, (Baqutayan, (2015). Indian Community Health Workers (CHWs) worked on the feedback that they got from the communities that they served and the health systems in order to gain skills and self-efficacy (Sarin & Lunsford, 2017).

Brunie *et al.,* (2014) found out that Ugandan Community Health Workers (CHWs) valued provision of bicycles over a small increase in transport refund. This helped them to cope with the challenge of transport. CHWs in Kisumu Kenya, engaged in income generating activities such as running a small business, paid domestic work and selling food, to boost them economically and hence positively cope with issues of insufficient funds. Research suggests that this was most adaptive strategy (Aseyo et al., 2018).

Emotion-focused Coping Strategy: This was when efforts were directed towards changing one's emotional reactions that accompanied the perception of stress (Baqutayan, 2015). Community Health Workers in rural South Africa were afraid of developing mistrust with clients hence, they continued working in spite of their situation, thus their dismal performance upset them (Mlostwa,

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Haris, Schneider & Mushabela, 2015; Sharma, Webster & Bhattacharya, 2014).

Female Community Health Workers (CHWs) in Rwanda gained authority, higher status and prestige in spite of their gender, as a result of the community recognizing their potential (Condo *et al.,* 2014). CHWs in Uganda gained community's trust, respect, recognition and self-efficacy, which boosted their morale. When they aspired for better opportunities, they remained in service and their satisfaction with helping the vulnerable counteracted the frustration of volunteerism (Brunie *et al*., 2014).

Avoidance Coping Strategy*:* This was when Community Health Workers (CHWs) directed their efforts to social networks or destructed themselves so as to evade the situation. CHWs took comfort in their affiliations to current programs and in possessing its identification tools e.g. badges and shirts. Researchers have proved this to be the worse strategy compared to the task oriented coping strategy (Pandey & Singh, 2015).

METHODOLOGY

The study adopted a survey research design which was cross-sectional in nature because it was done at a particular point in time. This was done by collecting data on the relevant variables from community health workers cutting across different Community and Faith Based Organizations in different sub-counties in Kakamega County. The study was done in Kakamega County which is one of the 47 counties in Kenya and it is found in the former western province. The study targeted all Community Health Workers (CHWs) in Kakamega County who were involved in programs supporting vulnerable children. The accessible population was Community Health Workers who were engaged in the Community and Faith Based Organizations (CBOs and FBOs) that were linked to Catholic Relief Services (CRS) which was the program supporting vulnerable children in the County. Those excluded from the study were community health workers in Kakamega County who were not working with Catholic Relief Services Mwendo program at the time of study. Also excluded were CHWs who declined to consent to the study due to unwillingness or in ability to take part in the study.

The researcher purposively selected six program coordinators of Catholic Relief Services Mwendo (CRSM) which was then the program supporting vulnerable children in Kakamega County at the time of the study. Interview schedule was used to get an in-depth understanding of the variables in the study. The tool was administered to the Community Health Workers by the researcher and two research assistants. It was preferred because it ensured a 93.2% response rate and completion of the items than self-administered questionnaires. Before commencing the study, pre-testing of the study instruments was conducted to ensure the proposed instruments tested what they intended to. The study generated both qualitative and quantitative data. Quantitative data was analyzed using Statistical Package for Social Sciences (SPSS) version 23.

FINDINGS

Challenges Facing Community Health Workers

The study explored the challenges that the Community Health Workers faced while on duty. The participants were therefore asked whether they faced any challenges in their Community Based Organizations and Faith Based Oorganizations. The findings were as follows;

Table 1: The proportion of CHWs who had faced challenges

	Frequency	Percent (%)
Yes	165	92.7%
No	13	7.3%
Total	178	100.0%

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Contrary 92.7% of the participants who said that they had faced challenges, 7.3% of them said they had not faced any challenges so far. This was echoed by the key informants who were all in agreement that indeed Community Health Workers in the program faced so many challenges.

"Of course they do! The challenges that they face are numerous! If being a CHW is not your passion, you may not remain as one for long". Key Informant 1 (KI 1) emphasized.

Challenges regarding Supervision of their work, Training, Workload, Transport and Stock out

The participants were asked to indicate whether they had faced challenges regarding supervision their work, their training, workload, transport, and stock out. The findings were as follows;

Challenge of Unsupportive Supervision: The participants were asked whether they had any challenges in respect to supervision in their CBO/FBO. From the findings 91.01% indicated that they had not experienced any challenges of unsupportive or insufficient supervision of their work while 8.99% of them indicated that they had indeed experienced such challenges.

Challenge of Community Health Worker Training for their work: Regarding the challenge of inadequate training, 75.84% of the community health workers indicated that they had not experienced any such challenges. On the contrary 24.16% indicated that they had experienced such challenges.

Challenges of High Workload: Regarding the challenge of high workload, nearly two thirds of the participants; 64.61% indicated that they had not experienced any such challenge. In spite of that, 35.39% of them indicated that they had experienced such challenge.

Challenge of Transport: On the challenge of transport, 90.45% of the Community Health Workers indicated that they had experienced these challenges. However, 9.55% had not experienced any challenges regarding transport. "Some *CHWs had to cover a long distance to get to the VC's homes hence in some cases they had to dip in to their pockets for fare which is rarely reimbursed*". Key Informant 2 (KI 2) said sympathetically.

Challenge of Stock out for CHW's Tools and Materials: Even though 69.66% indicated that they indeed had experienced stock out of tools and materials, 30.34% of the participants indicated otherwise.

Challenge of inadequate Funding: With reference to the challenge of inadequate funding, 91.57% of the participants said they indeed faced such challenges. This was not the case for 8.43% of them who said they had not experienced such challenges. *"Although community health workers were rewarded via stipend of Kshs. 2,000/= on a monthly basis, this was none the less very little and at times it is delayed for several months".* Key Informant 5 (KI 5) emphasized. According to the KI, inadequate stipend was the most pressing challenge to CHWs as this demotivated them.

Other Challenges Faced: Community Health Workers were asked to mention any other challenges they faced while on duty. Among those cited was distrust from care givers of vulnerable children especially in times of stock outs. Care givers tend to imagine that community health workers misappropriate the supplies in their custody. This was also cited by Key Informant 2 (KI2); "*Care givers tend to imagine that we benefit from the items intended for Vulnerable Children and this causes distrust".*

Additionally, the CHWs claimed that some of them were also vulnerable and this at times caused conflict of interest. *"Most of us are also vulnerable and this creates conflict of interest e.g when shelter was constructed for a vulnerable children household yet it was raining in the old grass thatched hut of the community health workers in charge! Additionally, there are some uncooperative Community members who hide evidence from the community health workers when a vulnerable child has been abused just to mention a few".* Lamented the Key informant 6 (KI 6).

Table 2: Coping Strategies adopted by Community Health Workers

Coping strategies	Frequency	Percent (%)
Negative coping	105	59.0%
Positive coping	73	41.0%
Total	178	100.0%

Additionally, the study sought to find out the coping strategies adopted by Community Health Workers (CHWs). This was to enlighten on how crucial coping is to their line of duty. Coping was measured using the 21 items in the Coping Inventory for Stressful Situations (CISS) tool (Golpelwar, 2014). This was a 5-point scale with scores ranging from Strongly Agree (with a score of 5) to Strongly Disagree (with a score of 1). The findings indicated 59% of the participants used negative coping since they scored a sum of up to 84 (score of 21-83) out of the total sum of 105. However, 41% used positive coping strategies as they scored a sum of between 84 and 105. (A score of 5 in all the 21 items gives a sum score of 105, while a score of 1in all the 21 items gives a sum score of 21, hence 105-21=84).

Besides, all the six Key Informants said that Community Health Workers (CHWs) talked to them (negative coping), about their challenges when they met in their cluster meetings. Key Informant 2 (KI 2) said "CHWs *at times got annoyed when faced with challenges yet they were trained to handle the situation. They however did not blame themselves for getting in to the situation".*

Furthermore, Key Informant 4 (KI 4) said *"CHWs often directed their queries to their Lead CHW in charge of a cluster of ten CHWs, who then forwarded the issue to the program coordinator Vulnerable Children's desk". (*Positive coping).

"For instance, a vulnerable child had been abused by her caregiver aunt in Butwsetsi, Khwisero Sub County. She used to assault and mal-handle the Vulnerable Child. The CHW from Khwisero SDA Dorcas who was in charge of the VC reported the case to CHW lead, who forwarded it to me (the program coordinator VC desk), we then set up a trap to get evidence, took the child to hospital and then we involved the police. The case is in Butere law courts as we speak" KI 4 said confidently.

Hypotheses Testing

H_0: There is no significant relationship between the Challenges faced and the Coping Strategies adopted by Community Health Workers engaged in Organizations supporting Vulnerable Children in Kakamega County.

The hypothesis was tested using chi-square test for independence to know if there was any relationship between the challenges faced by CHWs and the coping strategies that were adopted.

Relationship between the Challenges faced by CHWs and Coping Strategies

Table 3: Relationship between the Challenge of Insufficient/Unsupportive Supervision and Coping Strategies

Challenges of Unsupportive Supervision		Coping Strategies) Negative Coping	Positive Coping	Total
Yes	Frequency	9	7	16
	%	56.3%	43.8%	100.0%
No	Frequency	96	66	162
	%	59.3%	40.7%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=0.055, df =1, p=0.815

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As manifested in the Table 3, the challenge of unsupportive supervision had no significant influence on the coping strategies adopted by CHWs (X^2=0.055, df =1, p=0.815). This being statistically insignificant, the null hypothesis was accepted.

Table 4: Relationship between Inadequate Training for CHWs and Coping Strategies

		Coping Strategies		
Challenges of training		Negative Coping	Positive Coping	Total
Yes	Frequency	23	20	43
	%	53.5%	46.5%	100.0%
No	Frequency	82	53	135
	%	60.7%	39.3%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=0.709, df =1, p=0.400

From the Table 4, the challenge of inadequate training for CHWs had no significant influence on the coping strategies they adopted (X^2=0.709, df =1, p=0.400). The null hypothesis was accepted in consequence of this value being statistically insignificant.

Table 5: Relationship between the Challenge of CHW's High Workload and Coping strategies adopted

		Coping Strategies		
Challenge of High Workload		Negative Coping	Positive Coping	Total
Yes	Frequency	30	33	63
	%	47.6%	52.4%	100.0%
No	Frequency	75	40	115
	%	65.2%	34.8%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=5.2111, df =1, p=0.022and r=-0.171

Table 6: Spearman's Correlation Coefficient for Workload and Coping Strategies

			Coping Strategies	Challenge of High workload
Spearman's rho	Coping Strategies	Correlation Coefficient	1.000	-.171*
		Sig. (2-tailed)		.022
		N	178	178
	Challenge of High Workload	Correlation Coefficient	-.171*	1.000
		Sig. (2-tailed)	.022	
		N	178	178

*. Correlation is significant at the 0.05 level (2-tailed).

Results in the above tables revealed significant evidence to show that the challenge of high workload had a weak and negative influence on the adopted coping strategies (X^2=5.2111, df =1, p=0.022and r=-0.171). This was statistically significant because it was less than the P value of 0.05. Moreover, the r value was -0.171 which indicated that the challenge of high workload had a weak and negative relationship with the coping strategies adopted, the null hypothesis is accordingly rejected.

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Table 7: Relationship between the Transport Challenge and Coping Strategies

Challenges of Transport		Coping Strategies: Negative Coping	Coping Strategies: Positive Coping	Total
Yes	Frequency	96	65	161
	%	59.6%	40.4%	100.0%
No	Frequency	9	8	17
	%	52.9%	47.1%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=0.284, df =1, p=0.594

As manifested in Table 7, the challenge of transport had no significant influence on the coping strategies they adopted (X^2=0.284, df =1, p=0.594). So, the null hypothesis was accepted as a consequence of this being statistically insignificant.

Table 8: Relationship between Stock outs of Tools and Materials and Coping Strategies

Challenge of Stock outs		Coping Strategies: Negative Coping	Coping Strategies: Positive Coping	Total
Yes	Frequency	70	54	124
	%	56.5%	43.5%	100.0%
No	Frequency	35	19	54
	%	64.8%	35.2%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=1.088, df =1, p=0.297

From the Table 8, it was evident that the challenge of stock outs of tools and materials had no significant influence on the coping strategies adopted by the participants (X^2=1.088, df =1, p=0.297). The null hypothesis was thus accepted as a result of the value being statistically insignificant.

Table 9: Relationship between the Challenge of Inadequate Funding and Coping Strategies

Challenges of Funding		Coping Strategies: Negative Coping	Coping Strategies: Positive Coping	Total
Yes	Frequency	101	62	163
	%	62.0%	38.0%	100.0%
No	Frequency	4	11	15
	%	26.7%	73.3%	100.0%
Total	Frequency	105	73	178
	%	59.0%	41.0%	100.0%

X^2=7.074, df =1, p=0.008 and r=0.199

Table 10: Spearman's Correlation for the Challenge of Inadequate Funding and Coping Strategies

			Coping Strategies	Challenges of Funding
Spearman's rho	Coping Strategies	Correlation Coefficient	1.000	.199**
		Sig. (2-tailed)		.008
		N	178	178

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Challenges of Funding	Correlation Coefficient	.199**	1.000
	Sig. (2-tailed)	.008	
	N	178	178

**. Correlation is significant at the 0.01 level (2-tailed).

As seen in the tables above, there was significance evidence to indicate a weak and positive relationship between the challenge of funding and the coping strategies adopted by Community Health Workers (X^2=7.074, df =1, p=0.008 and r=0.199). This value is statistically significant because it is less than the P value of 0.05. Moreover, the r value is 0.199 which indicates that the challenge of funding had a weak and positive influence on the coping strategies adopted. The null hypothesis is consequently rejected.

So, with reference to challenges facing the participants, we can conclude that there was no relationship between the independent variables: challenges (supervision, training, transport and stock outs) and the dependent variable (coping strategies adopted) since the values obtained were not statistically significant. Therefore, the null hypothesis is accepted. Nevertheless, there existed a relationship between the independent variables; challenges (work load and funding) and the dependent variable (coping strategies adopted) since the values obtained were statistically significant therefore, the null hypothesis is rejected.

Key Informant 1(KI 1) however says otherwise,

"*These challenges did not in any way affect CHWs' performance at all, because they were volunteers and they had been sensitized on self-sustainability. Moreover, if the CHW's children met the criteria of VC, they were included in the program but were allocated to a different CHW. Moreover, the communities had been sensitized by the Local Area Advisory Committee (LAAC), on the importance of their cooperation with CHWs. The LAAC consisted of; the chief, few members of the community and the children' officer".*

Discussions: Contrary to the 92.7% of the participants who faced challenges, 7.3% had not faced any challenges so far. This affirmed the findings of Aridi et al., (2014) in rural Kenya. To more than three quarters of the participants, neither supervision nor training were challenges. Moreover, 64.6% of the CHWs had no challenges regarding high workload. None the less, there were challenges of unsupportive supervision, poor inadequate training and high workload as reported by CHWs in Philippines, Mozambique, Bangladesh, Indonesia and in Sub-Saharan Africa (Hill et al., 2014; Ndima et al., 2015; Kane et al., 2016; Gichaga et al., 2021). Besides, 90.4%, 69.7% and 91.6% of CHWs faced challenges regarding transport, stock outs and in adequate funding respectively. This was in agreement with the views of Brunie, *et al.*, (2014) who in his study in Uganda found out that CHWs experienced limited access to transportation. Moreover, the views of Oliver *et al.,* (2015), Aseyo et al., (2018) and White et al., 2017 were that insufficient materials to cope with the obstacles on the ground were a major challenge to South African, Ugandan and Kenyan CHWs. Baptistini & Figuelredo, 2014 also agreed that CHWs in Sao Paulo covered a large geographic distance in order to get to their clients. Additionally, Aseyo et al., (2018) and Gichaga et al., (2021) in their studies found out that CHW programs had unreliable sources of funding as was a major challenge.

Almost all the participants faced challenges in their line of duty. However, supervision and training did not influence the coping strategies they adopted (p=0.815; p=0.400). Workload negatively influenced the coping strategies that they adopted (p=0.022; r=-0.171). This meant that those CHWs who faced the challenges of workload were likely to use negative (emotion focused and avoidant) coping strategies and vice versa. This disagreed with the views of Rukhsana (2010) that there was a negative

relationship between workload and avoidant coping.

Besides, the findings indicated that the challenges of transport and stock outs did not influence the coping strategies that Community Health Workers adopted (p=0.594; p=0.297). Nonetheless, inadequate funding had a positive influence on the coping strategies adopted (p=0.008; r=0.199). This meant that when the challenges of inadequate funding were high, they mostly used problem focused coping strategy.

CONCLUSIONS AND RECOMMENDATIONS

Despite the fact that Community Health Workers (CHWs) played an important role in the healthcare, they faced many challenges while on duty to the point that some had arguably considered to stop serving as community health workers. The challenges faced were related to transport, stock out and funding. The challenge of Funding influenced the coping strategies adopted. This was not the case with neither the challenges of transport nor stock outs. However, supervision, training, and workload were not perceived as challenges and neither did they influence their coping strategies adopted, except for workload.

The study concluded that the challenges of high workload and in adequate funds had a negative and a positive influence respectively on the coping strategies adopted by these community health workers. These were the determinants of the coping strategies adopted by community health workers in this study.

In view of the findings from this study, the study recommended that guiding/counseling centers to be established by the organizations, for community health workers with challenges to get relevant help. This is because if community health workrs are left on their own to solve their problems, they may opt to use emotion focused and avoidance coping strategies which cannot provide much help. The national governments and donors should strongly invest in integrated CHW programs to enable equitable, efficient and effective use of the existing funding. They should support CHWs in terms of restocking of their supplies, in order to make their activities more visible and sustainable and to increase their impact on the continuum of services. Finally the study recommended that advocacy was needed at the county government level, to promote financial investment in community health and integrated service delivery, and to tackle challenges experienced by community health workers and to ensure they were well equipped to work.

Areas of Further Research

Additional research should be undertaken on the effects of the determinants of the coping strategies adopted by community health workers engaged in organizations supporting vulnerable children in Kakamega County and other counties within Kenya. It was also a recommendation that this research should be replicated in other sectors closely related to community health activities.

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