KENYA

Community Epidemic and Pandemic Preparedness Programme (CP3)

Qualitative KAP Survey Results

Community Epidemic and Pandemic Preparedness (CP3) Qualitative Survey Results: Kenya

Introduction

The Community Epidemic and Pandemic Preparedness Programme (CP3) strengthens the capacity of communities, Red Cross-National Societies, and other partners to prevent, detect, and minimise the impact of epidemics. It is working with communities to provide basic information about the spread of diseases and how to prevent them, simple and effective systems to detect outbreaks, and communication mechanisms to ensure timely information sharing.

As part of the Monitoring and Evaluation (M&E) Framework, a mid-line Knowledge, Attitudes and Practices (KAP) survey was conducted to generate evidence, measure changes and identify gaps in communities' understanding and practices about epidemic diseases. The process included household surveys, key informant interviews (KIIs) and focus group discussions (FGDs). The analysis of quantitative data from the household survey can be found at IFRC Go - Kenya This report presents the results of the mid-line qualitative data collected through KIIs and FGDs, making comparisons with the quantitative data collected in the household surveys. .

Method

The KAP assessment was carried out in August 7-11, 2023. It applied a mixed methods (qualitative and quantitative) approach to gather data. The qualitative methods applied a questionnaire of open-ended questions with individuals through KIIs and small groups of stakeholders through FGDs. The same thirteen questions were applied to both key informants and focus groups (see Annex 1). However, many of the questions had follow-up questions that were applied differently between the KIIs and FGDs. Data was analysed by sub-question, and as a result there are many responses that are categorized as "N/A" because there was no data for that specific question.

The questionnaire was carried out with 19 key informants and 12 focus group discussions (31 total interactions). The KIIs and FGDs were held across 23 villages within four target counties (see Table 1).

Table 1: Number of KIIs and FGDs by county

County	Number of villages	Number of KIIs	Number of FGDs
Bomet	5	5	3
Narok	4	5	3
Tharaka Nithi	8	5	3
West Pokot	6	4	3

KIIs were held with people of varying roles in the county (see Table 2).

Table 2: Type of key informants

Type of respondent	Number of KIIs
Veterinary workers	4
Health officials and workers	5
Community leaders	3
Religious leaders	4

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Farmers	1
CP3 and Community-Based Surveillance focal point	1
Ward administrator	1

The focus group discussions were held with five different types of groups (see Table 3).

Table 3: Type of participants in the focus group discussions

Type of participant	Number of FGDs
Men	2
Women	6
Youth	1
Community leaders	1
Mixed gender group	2

Data was analysed from the KIIs and FGDs using qualitative methods. Common themes were identified, and the responses were tagged accordingly. Descriptive statistics were used to show the frequency of occurrence of the themes. The FGDs were counted as one respondent/entry, even though there were multiple people in a group. Percentages are calculated as a percentage of total KIIs (N=19) and a percentage of total FGDs (N=12). The dataset did not include complete information on the gender of the key informants, so the results are not disaggregated by gender. Rather, data was disaggregated either by the type of data source (KII or FGD) or by district where relevant.

Engagement with Red Cross

The first question was about the respondents' engagement with the Red Cross. The majority of key informants indicated a frequent engagement with Red Cross activities. A third of FGD respondents indicated a similar frequency, while half indicated an irregular or occasional participation (see Table 4). Few respondents indicated that the engagement was rare or never.

Table 4: Frequency of engagement with Red Cross

Frequency	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Often	16	4	84	33
Occasional	0	6	0	50
Rarely	2	1	11	8
Never	1	1	5	8

In terms of the type of engagement with the Red Cross, respondents most commonly identified participation in the monthly meetings or community/engagement/dialogue meetings (see Table 5). The monthly meetings were organized to review progress or "*deliberate on what transpired in the month*." One of these key informants noted more regular contact through a WhatsApp group for CP3 and one for the school club.

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Table 5: Type of engagement with the Red Cross

Type of contact	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Monthly meetings	6	3	32	25
Contact with Community Health Promoters	2	4	11	33
Community activities	2	3	11	25
Limited/no contact	3	1	16	8
Community-based surveillance	1	1	5	8
Volunteer	1	0	5	0
Aware of activities	2	0	11	0
Community meetings	2	0	11	0

Many respondents of both the FGDs and some key informants noted that their contact was through the Community Health Promoters (CHP). This includes house-to-house visits, school visits, and health promotion activities.

> "*We do engage with CHPs more frequently and they also communicate messages from Kenya Red Cross to us. This also improves our contact with the Red Cross team*." – FGD of leaders from Bomet.

> "*We stay in touch with CHPs and doctors who specialize in both human and animal health...Together, we engage in sensitization efforts, spreading awareness about diseases*." – KII with a chief from Narok.

> "*We have had interactions with Community Health Volunteers (CHPs) within our local communities, where they have visited our homes. They have been also conducting visits to schools.*" – FGD with men from Tharaka.

> "*A CP3 CHP conducts community rounds to ensure hygiene practices. We receive valuable lessons on hygiene and sanitation from her, [and assesses] whether we have constructed toilets or not... We value this support and look forward to your continued assistance for our progress.*" – FGD with women from Narok.

A few respondents also noted that their contact with the Red Cross was in response to cases detected in the community, demonstrating the functionality of the community-based surveillance (CBS) system and the relation with CHPs.

> "*In cases of alerts, we always report to the CHPs who later report to CBS officials and the information is cascaded to the relevant authorities*." – FGD of women from Bomet.

> "*I've taken on the role of disease surveillance coordinator and joined the secretariat for the one health platform. I'm also tasked with the responsibility of receiving alerts and coordinating timely responses*." – KII with a County Veterinary Officer from Narok.

> "*The engagement with CHPs has been on incidences that happen within our community. When we have cows that show signs of sickness or are dead, we immediately call [our CHP] to guide us on what to do next*." – FGD with men from Narok.

Several respondents from both KIIs and FGDs noted their engagement was through the participation in Red Cross activities. The activities include awareness-raising and health promotion activities, such as school health clubs, training, clean-up activities, village education sessions, mobile cinemas and street theatres. A couple mentioned participating in vaccination clinics and another joining as a volunteer with the Red Cross.

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Immunization

The household surveys found an overall positive perception of vaccinations, with 99% believing they are good for children's health and 97% believing they prevent serious diseases, and 98% believing they are safe. There was a similar positive opinion about immunizations among both KII and FGD respondents. They were asked to provide their opinions on immunizations and whether they believe they prevent diseases. The majority of respondents noted that immunizations saved lives and prevented illness (see Table 6). A few did not respond directly or at all to the question about immunization saving lives.

Table 6: Do vaccines prevent diseases and save lives?

Response	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Yes	16	10	84	83
Not Answered (N/A)	3	2	16	17

Many of the FGD respondents spoke of immunizations being important or beneficial to the community. There was a very notable acceptance and use of vaccines for animals in particular. Those who found it important said:

> "*We always ensured our children and animals were immunized/vaccinated to ensure we are protected from diseases. Immunization is important to our community as we have seen a reduced number of health issues due to immunization and vaccination*." – FGD with mothers from Bomet.

> "*I believe in participating in the vaccination of our dogs and cows, as well as ensuring our children receive proper vaccinations. We've noticed that vaccinated children tend to stay healthier, experiencing less frequent pain and fever*."- FGD with women in Narok.

> "*Vaccines are important because animals can have diseases, and they live closely with people. If they bite people, they can transmit diseases. Vaccination helps prevent individuals from easily falling ill and helps when seeking medical care*." – FGD with women in Narok.

While there was an overall positive view of vaccinations, there were many nuanced answers. There was another sub-question asking respondents if vaccines are dangerous. Half of the key informants and focus groups either stated the benefits of vaccines or stated clearly that vaccines were not dangerous (see Table 7).

> *"I firmly believe that vaccines are not dangerous to our health. They undergo rigorous testing and are only brought to market once proven to be safe and effective*." – KII respondent in Narok.

> *"I'm convinced that vaccines are safe for everyone, both animals and humans. It's a smart and beneficial practice*." – FGD respondents in Narok.

> "*No, vaccines do not harm the human body. Instead, they prevent some of the diseases, in in the worst-case scenario, they can be easily treated to prevent further infections. I have not witnessed any harm from the vaccines even on children and this has greatly reduced health problems*." – KII respondent in Narok.

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Table 7: Are vaccines dangerous?

Response	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
No	10	6	53	50
Possibly	3	0	16	0
Misconceptions	3	3	16	25
N/A	3	3	16	25

Three key informants noted possible cases in which vaccines could be dangerous.

> "*Vaccines are safe but, if not handled well, can be dangerous. Anthrax is a life-attenuated vaccine when stored above expected temperatures can cause problems*." – KII with Animal Health Assistant in Bomet.

> "*Vaccines are not dangerous to our health, however in animals, some vaccines can be dangerous*." – KII with a health worker in Narok.

> "*Vaccines are not inherently dangerous, but proper handling is crucial. Maintaining the cold chain is essential. While some vaccines, like the rabies vaccine, are attenuated, others, like the anthrax vaccine, can be risky if misused*." – KII with County Veterinary Officer in Narok.

Those who expressed more nuanced views identified hesitation about immunization within the community. Respondents showed an individual belief in the importance of immunization but recognized that there were many myths and misconceptions held by other community members:

> "*People also shy off from immunization because of miscommunication, myths and misconceptions*." – KII with a health worker from Bomet.

> "*Immunization is generally good, except for some myths surrounding them such as infertility*." – KII with boda boda chairman from Tharaka Nithi.

> "*In this community, area residents usually do not rush for vaccines unless there is an imminent threat to human lives indicating a need for persuasion and sensitization*." – KII with a religious leader from West Pokot.

The recognition of misconceptions was often accompanied by the view that CHPs have an important role in increasing acceptance and convincing community members to get vaccinated.

In the household surveys there was a similar level of misconceptions found. Eight percent of respondents agreed that vaccines are dangerous and that they are a secret way to make one infertile/sterile. Eleven percent believed they are a trick of the Government.

Key informants and focus group respondents were also asked about the perceived barriers to getting immunized. On average, respondents identified two barriers. The most commonly identified barrier was access to health facilities (see Table 8). The main access issues were the long distance to health facilities and poor road networks. For those with animals, the long distance to community outreach sites combined with the cost of vaccines were key barriers to vaccinating their animals.

> "*The distance poses a significant challenge, particularly for women with children, leading them to prefer staying at home*." – FGD with men in Tharaka Nithi.

> "*We walk long distances for our animals to get vaccinated against rabies and anthrax. This is discouraging and tiresome… The veterinary officers always charge a certain amount to vaccinate animals that seems to be expensive to us especially those who own many animals. We, therefore, do not vaccinate all the animals*." – FGD of women from Bomet.

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Table 8: Barriers to immunization identified by respondents

Barriers	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Access to health facilities	6	4	32	33
Local availability of vaccines	4	3	21	25
Misconceptions/mistrust	4	3	21	25
Knowledge/illiteracy	4	3	21	25
Religious beliefs	2	3	11	25
Migration/absence	5	1	26	8
Attitude	1	3	5	25
No obstacles	2	2	11	17
Insufficient human resources	2	0	11	0
Cost of vaccines	0	2	0	17
Access to community outreach sites (veterinary)	0	2	0	17
Lack of resources and communication	1	0	5	0
Insecurity	1	0	5	0
N/A	2	0	11	0

The limited availability of vaccines was the second most common barrier cited. Respondents noted insufficient supply in the local facility, in their sub-county, or that they were only available on certain days of the week. The challenge of availability was noted both for vaccines for humans and those for animals.

> *"The main challenge lies in resource availability and timely response. Unlike in the past, we lack vaccine reserves."* – KII respondent from Narok.

> "*We encounter a challenge with our health facility, which restricts the vaccine administration to Wednesdays only. The healthcare workers have explained that this limitation is due to issues with the functionality of the refrigeration equipment*." – FGD respondents in Tharaka.

Misconceptions and myths about vaccines were another common barrier, as well as illiteracy, a lack of knowledge, and religious beliefs. The types of misconceptions mentioned were about the side effects, vaccine safety, the potential harm vaccines cause to people or animals, and a general distrust in the government. However, it was also noted that with more information and understanding there was more acceptance of vaccines.

> "*I think there is a perception in the community that vaccines cause the death of people thus they cannot get vaccinated*." – FGD with a church community group from West Pokot.

> "*Few people who do not vaccinate animals feel the government is disposing of dangerous vaccines and is broke to get money thus imposing charges on the vaccination of dogs and animals*." – KII with an animal health assistant from Bomet.

> *"Some individuals hold misconceptions that lead them to resist having their children immunized at a young age. Overcoming these traditional beliefs is a major challenge*." – KII with a health worker in Narok.

Another important barrier was related to people's livelihoods. There are many pastoral households and people migrating for work. Several respondents noted that parents were absent during vaccination campaigns. This was particularly problematic as it meant children were unable to start or complete their vaccination programme.

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"Lack of completion of the vaccination programme has always been an obstacle, especially for the pastoral households migrating to the neighbouring country." – KII of health worker from West Pokot.

"You cannot administer a vaccine to a child without parental consent, so you have to come back the following day only to find them already gone to work. This would happen until the vaccination period ended." – KII with a pastor in Narok.

The other barriers identified were attitudes that vaccines were not necessary or a priority, that there was a lack of human resources at facilities, and problems of insecurity affecting vaccination campaigns.

Ebola

Household surveys found a low level of knowledge of signs and symptoms of Ebola. Less than a quarter of respondents identified any one symptom. The three most common symptoms report were bleeding (21%), high fever (14%) and severe headache (11%). Similarly, less than a third of respondents identified modes of transmission. The main form of transmission identified was shaking hands with an infected person (29%), followed by other physical contact with an infected person (14%), burial practices involving contact (12%), and blood of an infected person (8%).

During the interviews, key informants were asked about the signs of epidemic diseases and specifically whether they can identify three signs of Ebola. FGDs were not asked about the signs of Ebola, as Ebola had not been a prioritized disease in CP3 areas except in West Pokot after the outbreak in Uganda. More than half of the key informants were able to identify three signs of Ebola (see Table 9). Another fifth could identify one or two signs of Ebola. However, some of these respondents recognized that others in the community would not know the signs. Sixteen per cent of respondents either did not know the signs of Ebola or said that the community would not know the signs. Those who did not know the signs of Ebola acknowledged that it was partly because it has not been experienced in the area.

"*I know the signs of Ebola which includes headache, oozing of blood from body openings and feeling tired among others but the community members do not know. They confuse them with other diseases*." – KII with an animal health assistant in Bomet

"*We have heard of Ebola from a distance, but we haven't experienced it here. So, we haven't educated the community on Ebola's signs, and if you were to ask anyone about them, they might not know since we have not seen the need to have widespread awareness of the disease*." – KII with a chief in Narok

"*I have only heard of Ebola. I heard that if an infected person coughs around you or shakes your hand, you would get infected as well. This got me worried, and I just prayed for God's protection*." – KII with a pastor in Narok

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Table 9: Number of signs and symptoms of Ebola that respondents can identify

Response	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Identifies 3 signs	10	0	53	0
Identifies 1-2 signs	4	0	21	0
Cannot identify signs	2	0	11	0
Community does not know signs	3	0	16	0
N/A	0	12	0	100

Participants were also asked about their perceptions of Ebola Treatment Centres. They were asked specifically if people discharged from an Ebola treatment centre can safely come back to the community. The answers showed a distinction between the person's ability to safely return home and how the community would receive them.

> "*Yes, individuals discharged from Ebola isolation can safely return to the community. However, the obstacle lies in how they are received*." – KII with a chief from Narok.

A safe return was considered at the level of the individual, indicating that the treatment was complete and medically they were able to return. A quarter of key informants felt that there could be a safe return, without adding any qualifications or hesitations (see Table 10). A quarter of the focus groups would completely welcome them back without hesitation because they are part of the community.

Table 10: Perception of a person's ability to return safely to the community after an Ebola Treatment Centre

Perception	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Safe return	5	0	26	0
Continue isolation	12	4	63	33
Welcome	1	3	5	25
Mixed (welcome/isolation)	0	5	0	42
Do not go to treatment centre	1	0	5	0

> "*We would readily accept the person without objections. I have faith in our hospitals that they would release a patient only when fully recovered to prevent disease transmission*." – FGD of women in Narok.

> "*We love our people despite how sick they are and always try to make them comfortable in the community. They are always happy to come back to the community after getting sick, a sign of being safe in the community. However, I have never seen anyone with that disease in this area*." – KII with a traditional healer from Bomet.

> "*Yes, they can come back to the community because the patients have been treated already and are out of danger from the disease*." – KII from traditional healer from West Pokot.

More than half of respondents, however, expressed concern about a person's return. Most of these expressed that the person should continue in isolation either at their home or in the centre. There was a range of feelings, from mostly accepting but preferring limited contact to a lack of acceptance and fear of the disease. Within the FGD there were differing perspectives. Within the group, responses varied between complete acceptance to not accepting that they come back for fear of death. It is important to note that while some of the KIIs have technical knowledge of Ebola Treatment Centres, FGD participants have not be confronted to Ebola.

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"*I think it's okay for them to come back to the community as long as there are measures in place to ensure that they interact with others cautiously*." – KII respondent from Tharaka Nithi.

"*People discharged from the Ebola Isolation centre should not come back to the community safely. Most community members still perceive Ebola as a very dangerous disease and therefore, any interaction in the community should be limited as people believe that Ebola is a death sentence*." – KII respondent from West Pokot.

"*I cannot accept such a person into the community that easily because they can spread the disease to other people leading to loss of lives in the community*." – FGD of women in Bomet.

"*While the immediate family will undoubtedly welcome them back, the broader community might find it slightly challenging*." – FGD of men from Tharaka

One of the respondents noted that they would not go to the treatment centre to begin with.

"*For us, when someone is sick, we don't isolate them, we also don't seek for medical assistance, we instead pray for the person and they will be healed if they are pure in the heart*." – KII with traditional healer from Tharaka Nithi.

In the household surveys, participants were asked about actions to be taken for a suspected case of Ebola and not about Ebola treatment centers. There was a good awareness of the need to isolate the person (47%) or call a health centre (47%), and to a lesser extent go to an isolation unit (13%).

Safe and Dignified Burial

In the household surveys, participants were asked who are the key community decision-makers when it comes to safe and dignified burials (SDB). It must be noted again that respondants have not been confronted to the need to carry out SDB in their localities. There was a moderate awareness that health workers (49%) and authorities (35%) are key decision-makers, but it is also notable that the family is also considered an important decision-maker (42%). To a lesser extent, respondents identified neighbours (15%), the wider family (7%), clam members (6%), and religious leaders (6%).

In the interviews and focus groups, participants were asked who should be involved in SDB and who should lead. The responses gave an overall impression of their perception of SDBs (see Table 11). Half of informants and a quarter of focus groups expressed that SDBs were needed to prevent the spread of the virus. Another 16 per cent of informants and 41 per cent of FGDs accepted that people with expertise and protective gear needed to be involved.

"*There is a need to do a safe burial. Some diseases go with the 'wind.' When we don't do such burials properly, there is a high possibility of someone else getting the virus*." – KII with a boda boda chairman from Tharaka Nithi.

"*The community's perception of epidemics has shifted due to practical experiences like the COVID-19 pandemic. The fear and lessons from COVID-19 have made the community more receptive to understanding and adhering to modified practices to prevent disease transmission. Modern challenges have exposed the limitations of ancient beliefs*." – KII with a County Veterinary Officer from Narok.

"*Safe burials are very essential because there are measures put in place not to transmit the virus from the dead body*." – KII with a farmer from Tharaka Nithi.

Table 11: Perception of safe and dignified burial

Perception	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs

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Need for safe burial	10	3	53	25
Acceptance	3	5	16	41
Reluctance	2	2	11	17
N/A	4	2	21	17

However, there were a few informants and focus groups that expressed either reluctance or fear for SDB due to religious and traditional beliefs. These were found specifically in Bomet and West Pokot (see Table 12).

> "*There is no need for a safe and dignified burial because in case those involved do not bury the dead correctly the spirits may come to haunt us in the community*." – FGD of community leaders from Bomet.

> "*Only family members should be trained on safe and dignified burial. Those carrying out the burial were not considering the traditions of the community during Corona. We would thus not allow that again*." – FGD of community leaders from Bomet.

Table 12: Perception of safe and dignified burial by county and number of total key informants and focus groups

Perception	Bomet	Narok	Tharaka	West Pokot
Need for safe burial	3	3	4	3
Acceptance	0	4	3	1
Reluctance	3	0	0	1
N/A	2	1	1	1

Respondents identified many people who should be involved in the SDB, including community members, health workers, families, healthcare workers, village chiefs and leaders, health authorities, Red Cross. When asked who should lead the SDBs, more than half of key informants and a third of focus groups recognized either that it should be led by healthcare workers or health authorities (see Table 13). The healthcare workers mentioned were mainly doctors and medical specialists with protective gear, as well as nurses or experts from the Red Cross. The health authorities mentioned were mostly the Ministry or Health or public health authorities generally. A couple of respondents recognized that veterinarians should be involved in the safe burial of animals.

> "*The best person to lead the Safe and Dignified Burial according to my knowledge is trained specialists and medical experts with experience in handling dead bodies*." – FGD of a community group from West Pokot.

> "*I think the best people to lead the process are the health care workers in the county and community. Doctors who are specialized in the safe and dignified burial should lead the burial process*." – FGD of women in West Pokot.

> "*The Ministry of Health is the best to lead safe and dignified burial in the community. Safe and dignified burial should be conducted involving qualified medical personnel*." – KII West Pokot.

Table 13: Who should lead safe and dignified burials

Lead	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Healthcare workers	5	4	26	33
Health authorities	7	1	37	8
Family and health authorities	1	2	5	17

Public

Family and healthcare workers	0	2	0	17
Family	1	0	5	0
Community, religious leaders	1	1	5	8
CHP	1	1	5	8
N/A	3	1	16	8

However, although many recognised the need for health authorities or healthcare workers to lead, they often noted that it should be together with families or with leaders.

> "*Community members and family members are the best to lead a safe and dignified burial with the aid of the Ministry of Health. In most cases, the community feel safe when they are given the opportunity to bury their people*." – KII respondent from Bomet.

> "*The Ministry of Health should support the safe and dignified burial because the community does not have protective equipment to conduct a safe and dignified burial. Religious leaders should be allowed to offer spiritual support during safe and dignified burials in the community*." – KII respondent from West Pokot.

> *"Doctors should certainly be there, but even community members and family of the deceased should be involved. According to Maasai traditions, the family needs to be part of it*." – FGD of women from Narok.

> "*The responsibility of leading the process should rest with the family. The medical professionals should take the lead in conducting the burial*." – FGD of men from Tharaka.

The rest of the respondents said that the process should be led by either family members, community leaders (elders, religious leaders), or the CHP.

> "*I think family members can be allowed to bury their relatives in this case provided they are sensitized on the safety or precautionary measures to be undertaken*." – FGD of women from Bomet

> "*The best people to involve are CHPs because they are the most informed in the community. They are also the best link to the community and they understand the diverse traditional and cultural practices. The Maasai elders, I being one of them, also need to be incorporated because through them you are able to penetrate the community*." – KII respondent from Narok.

Participants of the household survey, interviews and focus groups were all asked about the consequences of not following traditional burial practices. In the household survey, there was most commonly negative feelings of sadness to the family (89 per cent), anxiety (85 per cent), and negative reactions in the community (72 per cent), as well as economic difficulties (60 per cent). The key informants also identified many of these negative feelings that the community would have about going against the traditions, that their rights are not respected, or it may cause psychological harm (see Table 14).

Among the FGDs, there was much greater recognition of the spiritual consequences. Half of the groups talked about spiritual consequences relating to the deceased person's spirit that will haunt the community or bring disease and bad fortune. Similarly, 34 per cent of the household survey respondents were concerned that the deceased's soul would not rest.

Table 14: Consequences if traditional burial practices are not followed

Consequence	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Spiritual - curse	1	6	5	50
Transmission	5	0	26	0

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Negative reactions	4	0	21	0
Conflict	2	0	11	0
Mistrust in government	0	1	0	8
No consequence	2	3	11	25
N/A	5	2	26	17

> *"If the dead are not buried following our traditions and beliefs, it is as if we lack respect for them and this might come back to us in the form of diseases and other calamities."* – FGD of women from Bomet.

> *"The main consequences are the spirit that won't make the village and community members have peace. They always follow the community because they feel the burial was not well done. Respecting the dead is our culture and we cannot run away from it*." FGD of community leaders from Bomet.

A few key informants mentioned the possibility of generating conflict within the community as well as mistrust in government. The household surveys showed greater concern over land-ownership issues resulting from the death (60 per cent).

> *"When you don't follow the traditional practices, the community will have mistrust issues on the government and agencies handling the burial and thus I think traditional burial practices should be followed."* – FGD of a community group from West Pokot.

> *"Neglecting traditional burial practices can lead to conflicts within the community and hinder effective disease management. Community involvement is crucial to prevent conflicts and ensure the cultural and spiritual needs of the community are respected*." – KII with a Public Health Officer from Narok.

Another quarter of the key informants respondents noted that the consequence of *not* modifying traditional burial practices would be an increased transmission of the disease.

> *"If communities are not engaged well there is the possibility of infection happening. Communities are to be taught how to observe traditional systems with caution."* – KII with a chief from Tharaka Nithi.

> *"In the context of epidemics, failure to follow modified burial practices can lead to widespread infections. Traditional practices that gather people from various places could result in national and international transmission*." KII with a County Veterinary Officer from Narok.

A quarter of the focus groups said that there would be no consequences if the traditional practices were not observed.

> "*There might not be any problem. Traditions have evolved, and people are more open to following disease prevention measures*." – FGD of women in Narok.

Response to an Outbreak

The household survey asked participants about reporting health risks. Nearly equal amounts said they report to a Red Cross volunteer (32 per cent), a health worker (25 per cent), a veterinary officer (24 per cent) or a community health assistant (16%). However, more than half (56 per cent) have never reported a health risk. For those that reported, there was a good response to the report. Either a community health promoter took action (55 per cent) or the local health facility staff or veterinary staff came (40 per cent). Only one per cent said that no action or response was taken.

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The key informants and focus groups were asked what they would do if they saw the signs of a serious possible outbreak disease and whether they knew where to report an alert. There was overall a high level of awareness among all groups about the process and where they would report an alert (see Table 15). They were able to identify either the process they would take and/or the people to whom they would report. One of the FGDs had mixed responses among the group. A couple of key informants were not aware or interested in reporting cases.

> "*Any disease that we may witness or experience, we turn to prayer. We don't believe in reporting to the police or anyone else; these are only earthly beings who cannot supersede God. Only God can heal, so we report to Him in prayer*." – KII with a traditional healer from Tharaka Nithi.

> "*I do not give out any alerts because culture and traditional medicines do not allow me to do so. Traditional medicines cannot be mixed with modern medicine. Once there is an outbreak, I simply look for traditional medicine and wait for patients*." – KII with a traditional healer from Bomet.

Table 15: Level of awareness of how to report signs of an outbreak disease

Awareness	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Aware	17	11	89	92
Not aware/Interested	2	0	11	0
Mixed response	0	1	0	8

The majority of those who demonstrated awareness of reporting alerts identified to whom they would report (see Table 16). Nearly half of the KII respondents said that they would report to the relevant authorities or healthcare workers, or their boss within the institution. The FGD respondents more often identified the CHPs either as the first point of contact or in addition to other local leaders (chiefs, village elders, traditional healers). Several participants noted that they would first isolate the person or seek medical treatment.

Table 16: Where to report a human epidemic disease alert

Report	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
CHP	1	3	5	25
CHP and Leaders	0	4	0	33
CHP and Health officers	2	2	11	17
CHP, chief and traditional healer	0	1	0	8
Health workers	4	1	21	8
Government/authorities	4	0	21	0
Local leaders	0	1	0	8
Hotline	1	0	5	0
Boss	1	0	5	0
Nearest chemist	1	0	5	0
God	1	0	5	0
N/A	4	0	21	0

Regarding outbreaks in animals, less than half of the key informants answered. Of those who did nearly all said they would alert the veterinary officers/departments or relevant authorities. One said they would report to a chief, another would call the hotline. Similarly, most of the focus group respondents identified veterinary and animal health personnel. A couple groups also identified animal disease reporters, CHPs, and village elders or chiefs.

Public

"*In case of an alert or outbreak, we dial *384*60 hash. You then choose the alerts, whether it is human, animal or zero alerts. I am now very confident in raising the alert after accessing the situation and confirming*." – KII with a ward administrator from Bomet.

"*We have a well-established reporting system in place. Whether it's a human epidemic disease alert or an animal epidemic alert, we promptly report these alerts to the sub-county authorities*." – KII with a health worker from Narok.

"I would inform the doctor who will take the next course of action. I am confident about informing the CHPs and animal health assistants because they are aware of the signs involved with these diseases." – KII with a veterinarian from Tharaka Nithi.

"*Firstly, I would isolate myself from close contact with the affected person or family. Secondly, I'd seek advice from a medical professional. For an animal disease, I'd involve a veterinarian. If it's a human disease, I'd reach out to the nearest Community Health Volunteer (CHP)*." – FGD of women from Narok.

"*We would reach out to the CHPs or doctors for assistance. The chief should be informed first to ensure that the community is aware of the potential dangers. Following that, the doctors should be notified to verify the nature of the disease*." - FGD of men from Tharaka.

"*We report alerts through our CHP. We receive alerts through mobile phones, often from organizations like Red Cross. These alerts provide information on various topics, including rainfall. There was a rabies problem previously when a dog bit someone. I sent an alert to our CHP*." – FGD of women from Narok.

There was a high confidence level in reporting signs of an outbreak disease to the identified person. KII respondents were mostly "very confident", while FGD respondents were mostly "confident" (see Table 17). In these cases, respondents were either confident in their own ability to report or they had confidence in the people they were reporting to.

Table 17: Level of confidence to report signs of an outbreak disease

Confidence level	Number of KIIs	Number of FGDs	Percentage of KIIs	Percentage of FGDs
Very Confident	10	3	53	25
Confident	4	8	21	67
Moderately confident	3	0	16	0
Not confident/interested	2	1	11	8

"*The CHPs are very effective, so I'm confident about raising these alerts to them. The issue would not be about the health officials acting fast on the issues. The main problem would be getting the medicine from the hospitals. Our local hospitals have not been well equipped*." – KII with a farmer from Tharaka Nithi.

"*I am confident to raise alerts to relevant authorities because we understand it is a measure to save the community from diseases. Some people fear to raise alerts to the authorities because they are afraid of the actions to be taken after that*" – FGD of women from Bomet.

"*I am also confident because I know the signs and symptoms of the cases and diseases related to humans and animals*." – FGD of women from Bomet.

Public

"*We are very confident when reporting the alerts as the community has been empowered by the government and specifically the Ministry of Health*." – FGD of a community group West Pokot.

There were a couple respondents who were not confident, not interested in reporting, or expressing fear of reporting. A few also identified constraints identified. There was less confidence where constraints were identified.

"*If it's a dog, we normally kill it. For a sick cow that could infect others, I'd isolate it and call a veterinary officer for treatment. If it dies, I'll bury it far away from others to prevent further contamination.....If I don't have a phone, there's no other way to report an alert. We can use the radio or seek the chief's assistance to gather people for a meeting and mobilization*." – FGD of men from Narok.

"You can tell the CHP but there is the cost incurred in involving the CHP." – FGD of youth from Tharaka.

"*Sometimes one can be scared in telling a particular vet because of their previous past experience, maybe an animal died in their hands before*." – FGD with youth from Tharaka Nithi.

Community Capacity to Raise Alerts

Respondents were asked about their perception of the community's capacity to raise alerts of potential human or animal disease outbreaks. FGD respondents were not asked the question. Of the key informants that answered, respondents most commonly said the community was only slightly ready (see Table 18). A quarter found the community moderately ready. A small but notable percent considered them very ready or extremely ready to raise alerts.

Table 18: Level of readiness to raise alerts

Level of readiness	Percentage of KIIs	Percentage of FGDs	Percentage of KIIs	Percentage of FGDs
Extremely ready	1	0	5	0
Very ready	2	0	11	0
Moderately ready	5	0	26	0
Slightly ready	8	0	42	0
N/A	3	12	16	100

Respondents were also asked how ready and able they are to raise alerts in comparison to the baseline. There was recognition that the communities are more ready, more able, and have more knowledge than before the CP3 programme. There is also recognition that the CHPs are a crucial factor in this readiness. However, at the same time, their readiness is constrained by the limited resources available, specifically the limited number of CHP resources compared to the need.

"*Before the CP3 intervention, people had no direction on how to go about the diseases but after project inception, there is an improvement in terms of reporting and dealing with such cases*." – KII with an Assistant Director of Health from Bomet.

"*They can moderately be able to raise and report but not to the extent of being perfect. Initially, the community was not aware of proper knowledge of this disease and lacked information thus reporting was even compromised. Without such support, the community had economic constraints in conducting sensitization and gatherings on the matter*." – KII with a ward administrator from Bomet.

Public

"*The community is able to report and raise alerts because the first and the last person to report to is the chief and I will definitely help them to escalate the alert.*"- KII respondent from Narok.

"The presence of CHPs is a crucial factor in the community's ability to respond effectively to health challenges. In contrast, villages lacking CHPs encounter obstacles in raising alerts and managing potential disease outbreaks." – KII with a health worker from Narok.

"*While we have a reasonable number of community health volunteers (CHPs), it's important to note that the workload they manage is substantial. CHPs often cover a significant number of households, sometimes exceeding 20 or 30 households each. The limitations of resources, such as the lack of motorbikes, can further strain their efforts, particularly when addressing issues in distant villages. In truth, we do not have an abundant number of CHPs to comprehensively cover the extensive villages within our region*." – KII with a Public Health Officer from Narok.

Respondents were also asked the follow up question of how vulnerable they believed the community is since the baseline. FGD respondents did not answer this question. More than a quarter of key informants believed that the communities were less vulnerable or no longer as a result of the programme (see Table 19). Almost half of the key informants, however, acknowledged that the communities remained quite vulnerable.

Public

Table 19: Perception of the level of vulnerability of the community since the baseline

Level of vulnerability	Percentage of KIIs	Percentage of FGDs	Percentage of KIIs	Percentage of FGDs
No longer vulnerable	1	0	5	0
Less vulnerable	5	0	26	0
Quite vulnerable	9	0	47	0
N/A	4	12	21	100

Community Preparedness

The households surveys found that respondents were had mostly a positive perception of the community's preparedness. Nearly three quarters (74 per cent) of the respondents felt the community was very prepared and another 21 per cent felt they were somewhat prepared.

The KIIs and FGDs were not quite as optimistic. They were asked how well prepared the community is to overcome epidemic diseases or emergencies. Only eleven percent of key informants and a quarter of FGDs felt the community was well prepared to overcome epidemic outbreaks (see Table 20). Key informants mostly viewed communities as either moderately prepared or slightly prepared. Meanwhile, a quarter of focus groups believed communities were not prepared.

Table 20: Level of preparedness of the community to overcome epidemic outbreaks

Level of preparedness	Percentage of KIIs	Percentage of FGDs	Percentage of KIIs	Percentage of FGDs
Well prepared	2	3	11	25
Moderately prepared	9	2	47	17
Slightly prepared	8	2	42	17
Not prepared	0	3	0	25
N/A	0	2	0	17

The ones that were positive about the level of preparedness acknowledged greater knowledge of disease prevention and how to report alerts, as well as a functioning system with sufficient resources.

> "*We are well prepared because we know how to report to relevant authorities, and we know the preventive measures*." – FGD of women from Bomet.

> "*I am confident that our community is well prepared to a significant extent, with a preparedness level exceeding 75%. This confidence is based on the availability of essential resources and strategic measures we've undertaken. For instance, when identifying potential epidemic risks, we strategically reposition stocks, ensuring that necessary supplies like ORS for cholera are readily available in vulnerable areas*." – KII with a Public Health Officer from Narok.

> *"Our community's readiness to combat epidemic diseases and emergencies has notably improved, primarily driven by our school engagement initiatives. Schools have emerged as effective channels for awareness and behaviour change."* - KII with a County Veterinary Officer from Narok.

> "*We are prepared to respond to epidemics as we have been trained by MOH on various diseases and their signs and symptoms. We have a number of handwashing facilities in the community, a sign of preparedness for any pandemic*." – FGD with women in West Pokot.

There were several reasons identified for not being prepared. The main challenges identified are:

Public

- the limited coverage by CHPs
- limited reach of the programme and its key messages
- lack of resources for the community to respond and recover
- persistent traditional beliefs and practices
- high illiteracy rates and limited knowledge among community members
- lack of protective equipment
- delays in reporting and response
- lack of resources and medicine in health facilities.

"*I would say we are slightly prepared because not everyone has been reached by the CHPs. There is also a lot of ignorance among the community members; they simply don't think these outbreaks can be serious*." – KII respondent from Tharaka Nithi.

"*I don't think we are well prepared because we don't have enough knowledge. Additionally, we don't have resources in terms of equipment and human resources. We are truly not prepared. Yes, we have been taught, but we are still lacking enough resources such as vehicles in this community*." - FGD respondent from Tharaka

The household surveys also identified the lack of money of resources (28 per cent) as a main reason for not being prepared. However, the other answers reasons were more fatalistic, that they don't know how to prepare (26 per cent), there is nothing they can do (16 per cent), it is not in their control (6 per cent), the Government has not told us what to do (8 per cent), or it is fate (6 per cent).

The key informants and focus groups identified several ways to improve the community's preparedness (see Table 21). There was a common recommendation to increase sensitization in various topics and to improve access to safe water. Several recommendations were related to the CHPs either to increase coverage, provide them stipends and transportation, or give them more training. A few mentioned improvements for animal health, including vaccinating animals, reducing costs, increasing the number of animal health assistants available, and improving the control of wild animals. Others sought improved access to health facilities, improved infrastructure and improved sanitation.

Table 21: Improvements identified by participants to increase preparedness

Improvements	Number of KIIs	Number of FGDs
Sensitization (more regular, in market centres, about hygiene, use of mosquito nets, avoid eating dead animals)	7	3
Access to safe water (drill boreholes, reduce distance, provide chemicals for water treatment, household water tanks)	4	2
Expand CHP network and coverage to more communities	2	3
Training for CHPs, equip with PPE	3	3
Economic (create employment, livelihoods, cash and voucher assistance)	2	0
Stipends and transportation for CHPs	2	0
Improve access to health facilities (build hospital, build a lab in the health facility)	1	4
Strengthen/expand One Health platform, enhance comprehensive contingency plans, inter-departmental collaboration	2	0
Engage leaders, village elders in sensitization and reporting	2	1
Vaccinate animals, responsible dog ownership	0	2
Reduce cost of vaccination, provide vaccines	1	1
Increase outreach sites for vaccination	0	1
Improve infrastructure, roads	1	1
Expand reach of CP3 programme, closer relationship with RC	0	2
Increase animal health assistants	0	1

Public

Improve public participation	0	1
Improve sanitation	1	0
Seek the Kingdom of God	1	0
Contain animals in game parks	0	1
Household visits by CHP	0	1
Database for centralized data analysis	1	0
N/A	5	0

Major Health Risks

Respondents identified the major risks that have an impact on the health of the community. The key informants and focus identified many risks, including diseases themselves and the various factors that can lead to diseases and other health issues (see Table 22). The household surveys found similar risks, including drought (28 per cent), diarrheal diseases (20 per cent) and malaria (11 per cent), as well as malnutrition (9 per cent).

Table 22: Major risks that have an impact on health

Major risks impacting health	Number of KIIs	Number of FGDs
Epidemic diseases (malaria, cholera, HIV, typhoid, diarrheal, measles)	4	6
Animal diseases and bites (anthrax, rabies)	4	1
Drought (affecting livelihood, food security, lose animals, water supply)	5	3
Lack of latrines, sanitation	3	3
Movement of and interaction with animals (cross-border, migration of wild animals, free movement of dogs)	3	3
Poor hygiene (especially in dry months)	3	2
Lack of access to clean water	2	3
Low vaccination (animals), limited availability of vaccines and supplies	1	3
Consumption of dead animals	3	1
Limited access to health facilities, distance	2	0
Floods and flash floods	1	0
Limited health and veterinary personnel	2	1
Cross-border movement of people	2	0
Negligence	0	1
Culture (e.g., disease spread during festive season)	1	0
Conflicts from clannism	1	0
Poverty, financial constraints	1	1
Sin	1	0

Several key informants and focus groups identified risk factors relating to animals, including the movement of animals, the interaction of humans and animals, the consumption of dead animals, and the limited vaccination and veterinary services available.

> *"The biggest risk is that of wild beast migration from Tanzania to Kenya. The wild beasts bring infections to our animals in this case cattle. The cattle are milked, and the milk consumed causes illnesses amongst community members. The cattle are also slaughtered, and the meat consumed infects community members. Another risk is a lack of access to clean water for household use which causes stomach infections, and they might spread among children when they meet and interact in school."* – KII with pastor from Narok

Public

"Drought causes food poisoning in cows, due to the concentration of prusik acid. Shortage of staff is also a risk and infiltration of quacks thus compromising the quality of services." - KII with veterinarian from Tharaka Nithi.

"When pastoralists take their animals at the border, they interact with Somalis. The limited number of veterinarians in the area results in insufficient coverage and increased vulnerability. Vaccination centres are located at a considerable distance. There is a lack of cattle dips in the vicinity. There is inadequate coordination among planning partners for mass vaccinations, often resulting in scheduling conflicts with market days." – FGD with men from Tharaka Nithi.

"*In drought we lack rain and our animals die of hunger due to drought. And when we lack our animals, we don't have other ways to sustain our livelihoods.*" – KII with a chief from Narok.

Others identified how the lack of access to water and poor sanitation lead to disease, such as cholera, diarrheal diseases, and urinary tract infections.

"The major risks that have the most impact on the health of this community include Typhoid outbreak in the community due to unhygienic practices and lack of toilet facilities, Malaria outbreak in the community due to breeding mosquitoes and Unknown diseases due to cross border movement across the neighbouring country." – KII with religious leaders from West Pokot.

"*Urinal Tract Infections especially for women is common because of lack of toilets and clean water*." – FGD of women from West Pokot.

Key informants and focus groups listed the main serious outbreaks or epidemic diseases in humans and animals in their area. The most commonly identified human diseases overall were cholera, malaria and Tuberculosis (see Table 23).

Table 23: Major human epidemic diseases identified by key informants and focus groups by county

Disease	West Pokot	Narok	Bomet	Tharaka Nithi	Total number of respondents
Cholera	1	2	2	4	9
Malaria	3	4	2	0	9
Tuberculosis	3	2	1	0	6
Diarrhea	2	3	1	0	6
Measles	1	0	0	4	5
Typhoid	1	4	0	0	5
Chickenpox	0	0	0	2	2
Flu	0	2	0	0	2
Pneumonia	0	2	0	0	2
Rift Valley fever	0	0	0	2	2
HIV	0	0	2	0	2
Intestinal worms	0	0	1	0	1
Kabonokia group	0	0	0	1	1
Urinary tract infection	1	0	0	0	1
Cancer	0	0	1	0	1
East Coast fever	0	0	1	0	1
Corona	0	0	1	0	1

"*As a community member, our main threat is tuberculosis because of the milk we drink from the cows. Some of us do not understand the best way of making milk*." – FGD respondent from West Pokot.

Public

"*During this period, there is usually a drying up of rivers, which limits the amount of water available for use. When this happens, cleanliness is not maintained; hence, some certain diseases are promoted. Even in the marketplace, cleanliness is not maintained, some areas look like 'dumpsites' which put the foods that we eat at risk of being contaminated*." – KII respondent from Narok

"Epidemics like cholera and other zoonotic diseases also jeopardize community health, exacerbated by poor sanitation and low latrine coverage. Animal bites, including snake and dog bites, add to the health risk." KII respondent from Narok

"*Cholera has been aggravated by the presence of a nearby river that serves as a connecting point for numerous communities. Unfortunately, improper waste disposal and cleaning activities in the river have led to the widespread transmission of the disease*." – FGD respondent from Tharaka.

The most common animal diseases identified were anthrax and rabies (see Table 24)

Table 24: Animal diseases identified by key informants and focus groups by county

Disease	West Pokot	Narok	Bomet	Tharaka Nithi	Total
Anthrax	0	2	7	2	11
Rabies	0	3	6	2	11
Foot and mouth disease	1	3	1	1	6
Contagious caprine pleuropneumonia (CCPP)	0	0	0	3	3
Bluetongue	0	2	0	0	2
Brucellosis	0	2	0	0	2
Newcastle	2	0	0	0	2
Contagious bovine pleural disease	1	0	0	0	1
Fowl pox	0	0	0	1	1
Goat plague	1	0	0	0	1
Orkipel	0	1	0	0	1
Peste des Petits Ruminants (PPR)	0	1	0	0	1

The respondents also identified several difficulties in making improvements to address the risks. The household surveys found that the prominent difficulties were the difficult financial situation (76 per cent), no resources or materials (43 per cent) and a lack of knowledge (34 per cent). The key informants and focus groups corroborate these difficulties and expand on several more types of difficulties (see Table 25).

Table 25: Difficulties in making improvements to address risks

Types of difficulties	Number of respondents (KII and FGD)
Knowledge and attitudes	13
Safe water	10
Financial	9
Access to health services	8
Sanitation	7
Environmental risks	6
Proximity to wild animals	4
Migration	4
Coordination	4
Limited CHP	3
Communication channels	2

Public

The types of difficulties encountered were grouped as follows.

- *Knowledge and attitude*: Respondents said that community members lacked knowledge of diseases and their symptoms, chose treatment over prevention, or were unwilling to adopt behaviours. There was specifically failure to adopt hygiene and healthy practices, not using mosquito nets properly, and vaccine hesitancy.
- *Safe water*: Access to safe water was a recurring issue. This included not having a source of safe water, lack of proper water storage, water scarcity leading to drinking from contaminated rivers, not treating water, and animals and humans drinking from the same water source.
- *Financial constraints*: Poverty and limited financial resources were cited as barriers to getting animals vaccinated, installing water storage facilities, latrines or boreholes, or installing fences to keep livestock away from wild animals.
- *Access* to health services: There were challenges with accessing health facilities, emergency services, and health personnel (including veterinary officers). There were also difficulties accessing vaccines due to limited supply (human and animal).
- *Sanitation*: There were poor sanitation practices and infrastructure. Respondents cited open defecation, poor hygienic practices, and cultural beliefs limiting the use of toilets.
- *Environmental risks*: A few environmental factors caused difficulties, particularly heavy rainfall bringing contaminants into water sources or that creates mosquito breeding grounds.
- *Proximity to wild animals*: Communities are located near national parks with wild animals or communities with stray dogs in the streets.
- *Migration:* The migratory pastoral lifestyle and the cross-border movement of people and animals increases risk of spreading diseases.
- *Coordination and engagement:* There are challenges with coordination with other sectors and partners, and a limited engagement of local leaders during interventions on epidemics.
- *Limited CHPs:* There are limited number of CHPs in relation to the need. They are overwhelmed, lack a stipend, and may be discouraged as they are sometimes overlooked by the community.
- *Communication channels*: When schools are closed, messages are not able to be passed from students to households. During outbreaks, messages can't easily be share in barazas/gatherings.
- *Religion:* There are religious beliefs that "calamity" follows those who are not on the right path.

Further explanation of some of the difficulties encountered are below.

> "*The dogs with rabies and wild animals come from Maasai Mara Park during the dry season. They bite our dogs and leave remains of what they have consumed. These are later eaten by our dogs and animals, increasing the spread of diseases in this area*." – FGD of women from Bomet.

> *"The Anthrax bacteria of earlier dead animals still exist in the soil and they are exposed during the rainy season through grasses which the animals consume. This makes it difficult to address the risks of Anthrax in our area*." – FGD of women from Bomet.

> *"Fetching water from a shared source complicates matters. Even if one is careful, others might contaminate the water source. Dogs and cows also use the same water source*." – FGD respondent from Narok.

Public

"Many residents are reluctant to adopt the simple and cost-effective measure of boiling water, which is a fundamental step towards ensuring safe drinking water. This resistance is partly attributed to financial constraints that limit their ability to purchase water or invest in boreholes." – KII respondent from Narok.

The household surveys confirm that sanitation is an issue in the communities. A third of respondents (33 per cent) sometimes practice open defecation, and 10 per cent always do. The main reason cited is due to a lack of latrine (18 per cent).

Influential People

Respondents identified the most influential people regarding human health and animal health. Each respondent identified several influential people. For human health, CHP were most commonly identified as influential, followed by community leaders (see Table 26).

Table 26: Influential people for information on health

Influential person	Number of respondents (KII and FGD)
Community health promoters	23
Leaders	20
Religious leaders	11
Health workers	8
Authorities	5
Household member	4
School	3
Red Cross	2
Professionals	2

Though most viewed CHP as very influential, there were also some that noted they were not influential either due to credibility or absence.

"CHPs are the most influential because they are close to the community and can influence changes due to continuous contact with them." – KII respondent from Bomet.

"*Prominent community figures, including the chief, church leaders, political representatives, village elders, and Community Health Volunteers (CHPs), hold the potential to garner community adherence to essential health practices*." – KII respondent from Narok.

"*Community Health Volunteers are not much influential to the community because they always interact with them in the community and are despised by a section of learned people in the society. However, people at the same time appreciate the work of CHPs because of the sensitization done*." – KII respondent from Bomet.

"*I have not witnessed the presence of Community Health Volunteers (CHPs) in our area, which raises doubts about their suitability for addressing our healthcare needs*." – FGD respondent from Tharaka.

To a lesser extent, respondents identified schools and teachers, professionals, and the Red Cross. 13 percent identified members of the household, noting traditional gender norms:

"*For the Maa Community, leveraging the influence of fathers at the household level could have a profound impact, given the traditional gender roles and patriarchal nature of these communities*." – KII respondent from Narok.

Public

"*Lead Mothers have an influence when it comes to human health more so those related to children and expecting mothers*." – FGD respondent from Bomet.

Regarding animal health, a quarter of the respondents did not identify anyone. Of those that respondent, they most commonly identified a veterinary professional, such as a veterinary assistant or officer (see Table 27). This was followed by CHPs and community leaders.

Table 27: Influential people for information on animal health

Influential person	Number of respondents (KII and FGD)
Veterinary professional	18
Community health promoter	10
Community leader	8
Health practitioner	3
Community disease reporter	2
Government	1
Religious leader	1
N/A	8

"*On animal health the village elders and chiefs are influential because they are the people who do contact the veterinary officers in case of challenges*." – FGD respondent from Bomet.

"*Veterinary officers are influential when it comes to animal health. They always treat our animals and give us information on different diseases*." – FGD respondent from West Pokot.

To a lesser extent, respondents identified health practitioners, community disease reporters, religious leaders, and the Ministry of Health.

Sources of Information

Key informants identified several sources from which they receive health information. Focus groups did not respond to this question. The most common sources of information were community leaders and through local radio (see Table 28). Key informants also identified governmental departments as sources of information. Another important forum for information is at community gatherings and functions, such as barazas, funerals, circumcisions. A few respondents identified people such as health workers, veterinary professionals. Communications channels such as television and phone/SMS were also identified by a few respondents. To a lesser extent, there were other channels identified, including social media, posters and hotlines, and spaces like churches and schools.

Table 28: Sources of information identified by key informants

Source of information	Number of key informants	Percent of key informants
Leader	8	42
Radio	7	37
Community health promoter	6	32
Government	4	21
Community activities	4	21
Television	4	21
Health worker	3	16
Phone	3	16
Veterinary officials	2	11
Social media	2	11

Public

Poster	1	5
Hotline	1	5
School	1	5
Church	1	5
Red Cross	1	5
No source	1	5

Highlights of the sources of information include:

> "*They also prefer getting information from schools. Children pass information to family members and other community members faster, which is normally taken seriously*." – KII Bomet
>
> "*The community also receives health information from community activities such as weddings, funerals, and circumcision sessions. Mass media such as TVs and local radios such ad Kass, Chamgei, and Emoo FM also provide updates and information on health issues in the community*." – KII respondent from Bomet.
>
> "*Social platforms like WhatsApp also facilitate information sharing. National government sources play a crucial role, providing official updates on diseases such as Ebola, Marburg, and polio*." – KII respondent from Narok.
>
> "*I get many updates from radios, televisions, short messages and medical practitioners who come to our village regularly. Chiefs and village elders also provide us with different information and updates concerning health during barazas and community functions*." – KII respondent from Bomet.

One respondent noted that they do not seek outside information:

> "*We don't tolerate anyone from outside coming to tell us any health updates. TV and radio only bear earthly information which is sinful. We burnt our TV and radio a long time ago*." – KII with traditional healer from Tharaka Nithi.

Communicating Key Messages

The participants were asked what key message they would give to their community and what are effective ways to communicate messages. The main messages they would deliver are about the following:

- Prevention is better than treatment
- Put learning into practice
- Communicate the impact of not taking preventive measures
- Communication on the signs, symptoms and preventive measures
- Importance of good hygiene practices
- How to handle dead animals and avoid eating carcasses

> *"Prevention is better than cure, we better prevent the spread of diseases than going out to look for a cure that may not be of help more so during these challenging financial times"* – KII respondent from Bomet.
>
> "*Preventive measures are also necessary because during dry spell there are increased cases of diarrhoea especially after rains diseases like anthrax becomes widespread. People, therefore, need to vaccinate their dogs before the rainy seasons*." – KII with an Animal Health Assistant from Bomet.

Public

"*I think community members should be told about the importance of proper handwashing and the use of latrine facilities in the Households thereby reducing costs involved during the treatment of diseases*." – FGD of women from West Pokot.

"The community's foremost message is to avoid consuming dead animals or cadavers. Prompt reporting of any unusual conditions in humans or livestock to community health volunteers or animal disease reporters is crucial. This quick reporting ensures timely intervention and control." – KII with a County Veterinary Officer from Narok.

The respondents identified various ways to communicate messages. They identified different media and many of the influential people in their communities. The most common answer was through community gatherings and specifically barazas, which are community meetings led by the chief (see Table 29). The church was another gathering space that was commonly identified. Many also mentioned using radio, and they identified local stations and times that would be most effective. Individuals also mentioned means such as posters, social media, men, and mobile cinema.

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Table 29: Effective means of communicating key messages identified by key informants and focus groups

Communication means	Number of KIIs	Number of FGDs
Community meetings and barazas	20	13
Church	7	5
Radio	6	6
Community health promoter	6	3
School	2	3
Health worker	3	1
Phone	2	1
House-to-house visits	0	3
Leaders	0	3
Social media	1	1
Veterinarian	2	0
Men	1	0
Mobile cinema	0	2
Posters	0	2
Red Cross	0	1
Referral	1	0
Law enforcement	1	0
N/A	3	0

Highlights of the suggestions of means to communicate key messages include:

> *"Utilizing vernacular radio stations like Sidai FM, Maiyan FM, and Citizen Radio during prime-time slots such as 10 am, 1 pm, and 7 pm can help reach a wider audience and ensure the messages are heard by many. By employing these communication channels, we can better inform and empower the community to take proactive steps in preventing outbreak diseases*." – KII respondent from Narok

> "*The most effective ways to communicate key messaging on epidemics is through interpersonal communications during barazas, monthly review meetings, quarterly review meetings and local radio programmes are the ideal*." – KII West Pokot.

> "*I think the use of local vernacular radio stations e.g., Kokuo radio station in Loisam would be the best medium since it can reach many people*." – FGD of women from West Pokot.

The means of communication identified largely coincides with their previous responses about influential people and sources of information.

Conclusions and recommendations

There was frequent engagement with the Red Cross through community meetings and through contact with CHPs. There is evidence that the health promotion efforts led by CHPs are reaching some community members and improving knowledge on epidemic diseases and their prevention.

There is generally positive view of immunizations, with a large number of respondents acknowledging its benefits. Though largely viewed as safe, there are persistent misconceptions and vaccine hesitancy. The CHPs have been influential in convincing community members to get vaccinated. However, the distance to health facilities and pastoral lifestyle of the communities are barriers to receiving and completing immunization programmes.

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There was also good awareness and acceptance of vaccination of animals. However, there were concerns about the safety of the vaccines when not handled properly and cold chain issues were problematic. The distance to facilities, lack of veterinary staff, and the cost, which leads to mistrust of the government, are key barriers to getting animals vaccinated.

Communities have not experienced Ebola and so there is limited awareness of the symptoms and treatment. There is stigma towards patients who have recovered and a fear that they are still contagious after leaving the Ebola treatment centre. While there is a general understanding of the need to practice safe and dignified burials that are led by health professionals, there is a reluctant population who would respond negatively if traditional practices were not followed.

There is a good awareness of human and animal diseases, the risk factors, and the process to raise an alert. There is a divergence in the views of community preparedness between the household surveys and the KIIs and FGDs. Challenges identified include a limited coverage of CHPs in the communities, limited financial resources, lack of knowledge, limited access to safe water and health facilities, droughts and floods, and the free movement of animals.

Based on the findings of the KAP qualitative and quantitative survey results, key recommendations for the CP3 programme in Kenya are:

1. Continue to carry out sensitization activities, sharing key messages at community meetings (barazas), in church, over radio, and by local leaders.
2. Strengthen the capacity and coverage of CHPs to do health promotion. Support CHPs to encourage community members to get vaccinated and address misconceptions
3. Communicate with the leaders and community members to find days/times that population will be present to receive vaccinations and communicate about upcoming vaccination campaigns.
4. Work with religious leaders and traditional healers both to enhance their knowledge about epidemic disease prevention and to support them as influential people within the community.
5. Continue sensitization activities on measures to prevent malaria, measles, TB, cholera, water-borne illness, and Ebola. Enhance knowledge on the symptoms and treatment of Ebola, misconceptions of the disease, and address stigma of patients returning from treatment centres.
6. Expand awareness campaigns on zoonotic diseases, especially rabies and anthrax, with prevention messages about avoiding the consumption of dead animals and vaccinating animals, addressing misconceptions.
7. Work with the community, local leaders and religious leaders on safe and dignified burial to increase acceptance and minimize potential negative social and emotional consequences.
8. Complement awareness activities with initiatives to address risks, such as improving access to safe water and improved sanitation and working with authorities to address issues of access and availability of human and animal vaccines.

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Annex 1: Questionnaire for key informants and focus group discussions

1. **Participation in Red Cross Activities.**
- How often engagement meetings with partners and the Red Cross take place?
- How much contact do you have with the Red Cross?

2. **What is your opinion on immunization?**
- Are vaccines dangerous to our health?
- Do vaccines prevent serious diseases and save lives?
- What do you think is the greatest obstacle in implementing immunization programmes?

3. **Know the sign of Epidemic diseases**
- Can you please give me at least 3 signs of EBOLA?

4. **Perception of Ebola Treatment Centres.**
- Can the people discharged from Ebola isolation come back to the community safely? Why?

5. **Safe and Dignified Burial.**
- If there is a need to do a safe burial because of an outbreak disease, who should be involved?
- Who is the best to lead SDB?
- What are the consequences if traditional burial practices are not followed?

6. **What would you do if you thought you saw the signs of a serious, possible outbreak disease?**
- Know where to report an alert i) human epidemic disease alert; ii) animal epidemic alert
- How confident are you about raising these alerts?

7. **Perceived current capacity of the community to raise alerts of potential human or animal disease outbreaks.**
- How ready and able are you at the baseline?
- Or how vulnerable you are?

8. **To what degree do you feel that your community is well prepared and easily able to overcome epidemic diseases or emergencies?**
- If not prepared, why not?
- What changes / improvements are required?

9. **What do you feel are the most major risks that have most impact on the health of this community?**
- What are the main serious outbreaks or epidemic disease in your area?

10. **What makes it difficult for them to make improvements to address these risks?**

11. **Who is most influential on the people in this community, regarding their practices of**
- Human health
- Animal health

12. **What are the main sources from which you receive health information and updates?**

13. **What would be the most important messages to give community people here to inform them of how to stop outbreak diseases?**
- What would be the most effective ways to communicate those messages to them?

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