

Audience Motivation Strategies for Community Participatory Decision-Making on Health Issues Among Pastoralist Communities: Case of the Maasai Community from Kajiado County, Kenya

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DOI: <https://doi.org/10.47772/IJRISS.2025.91200084>

Received: 15 December 2025; Accepted: 22 December 2025; Published: 01 January 2026

ABSTRACT

Several studies have examined the role of community engagement in health initiatives, revealing that resource inadequacies, cultural barriers, and a lack of awareness impede community participation. However, these studies primarily focus on single health conditions and urban or sedentary populations, leaving a notable contextual gap. Moreover, while many prior works rely on secondary data or qualitative methods, limiting the generalizability of their findings, there is a lack of research that utilizes a mixed-methods approach to provide a more comprehensive understanding. This paper addresses these methodological and contextual gaps by investigating the audience motivation strategies that can help improve community health outcomes among pastoralist populations in Kenya. It adopts a mixed-methods research design, collecting and analyzing both primary qualitative and quantitative data to provide a robust and holistic understanding of the subject. The findings explained in this paper are expected to offer actionable insights for policymakers and health organizations in order to design more effective and culturally sensitive health interventions for pastoralist communities.

Keywords: Community health, pastoralist communities, Community Engagement, public participation.

INTRODUCTION

Pastoral communities are always on the move, moving from one place to another, looking for pasture and water for their livestock. This paper seeks to understand community participation that helps in alleviating health challenges facing the Maasai community due to their nomadic lifestyle. The key focus for addressing this will be on exploring the audience motivation strategies that aids in this.

BACKGROUND

Community health systems are a cornerstone of public health, particularly in regions with limited access to formal healthcare infrastructure. Globally, community-based healthcare approaches have proven effective in improving health outcomes in underserved populations by utilizing locally embedded solutions, health promotion, disease prevention, and responsive care models (Perry et al., 2017). These systems often rely on community health workers, mobile health initiatives, and participatory approaches to bridge the gap between formal health institutions and populations in remote or marginalized areas. However, such systems must be context-sensitive, especially in environments marked by poverty, mobility, and weak infrastructure. In pastoralist communities, which are typically located in arid and semi-arid lands (ASALs), the delivery of healthcare faces unique constraints due to their nomadic lifestyles, environmental challenges, and socio-cultural dynamics (Tugjamba et al., 2023; Singh & Kerven, 2023). These challenges necessitate flexible, mobile, and culturally competent healthcare interventions tailored to their unique needs.

Pastoralism is a major undertaking in Africa, with researchers estimating that between 250 and 268 million people across Africa depend on pastoralism as their source of living (Wangui, 2024). Most of the pastoralists are concentrated in the Sahel region, which occupies 5.7 million hectares where approximately 13% of the entire West and Central Africa live (Černý et al. 2023). The Intergovernmental Authority on Development (IGAD) region, which entails most counties in East Africa, including Kenya, Ethiopia, Uganda, Sudan, Somalia, Djibouti,

and South Sudan, is approximated to have pastoral communities occupying 70% of the region's arid and semi-arid lands (ASAL). In Sudan, for instance, enhanced health that enhanced health access is most effective during the time when the pastoralists are in one camp (Muchiri et al. 2023). Among pastoralist families, women, especially those who are pregnant, face heightened risks due to the distance from health facilities (Beyene et al., 2025; Wulifan et al., 2022).

Across Africa, pastoralist communities in countries such as Ethiopia, Somalia, and Nigeria face compounded health challenges linked to their livelihoods, mobility, and environmental vulnerability. For example, Tschopp and Kidanu (2024) posited that 80% of Ethiopians depend on in animal rearing for subsistence. Reports have confirmed that this economic engagement is not without challenges and is cross infection for animals. For example, Brucellosis is reported to affect 8.8% in livestock and 41.6% in people. The pastoral communities in Somalia and Ethiopia also suffer from watery diarrhoea and malnutrition, stemming from climate change (Muhummed et al. 2024). Tolulope et al. (2025) reported that the fate of pastoralists in Nigeria is complicated by adverse weather condition stemming from climate change. Communities are uprooted from their ancestral land to look for pasture and water from their livestock, far from medical amenities.

In Kenya, the Rift Valley, where Kajiado County is located, stretches across the country and is home to many pastoralist communities (Gichuki et al. 2024). The regions, particularly the ASAL regions of Kenya is burdened by diseases. According to Kenny et al. (2022), absolute poverty levels in these ASAL regions range between 85% and 89%, significantly undermining access to healthcare. Women in these communities are especially vulnerable due to inadequate access to family planning services and maternal healthcare Furthermore, the interaction between domesticated livestock and wildlife in the vast open plains facilitates the transmission of zoonotic diseases. Such places have become a dangerous place where 60% of human pathogens, out of 1400 species of infectious disease pathogens which impact human beings are spread (Muga et al. 2021). The spread of the disease is made easier by the cultural practices which involve animal sacrifice (Muga et al. 2021). For example, Rift Valley Fever, which is a viral disease, which is a danger to both human beings.

Rationale of study

The goal of the study was to investigate audience strategies that can effortlessly lead to community participation especially in decision making processes pertaining to their health situation. This is because every human being has a right to access health facilities when they fall ill. However, one cannot go to the hospital and access such provisions if he or she is not informed about health messages. That is, if he or she does not know of the necessity to take care of their nutrition, for instance, physical health and even simple proper hygiene.

Statement of the Problem

Pastoralist communities in Kenya, particularly the Maasai of Kajiado County, continue to experience disproportionate health challenges despite decades of policy interventions and donor-supported initiatives. These challenges are exacerbated by their nomadic lifestyle, poor road infrastructure, limited healthcare facilities, and deep-seated cultural barriers that influence health-seeking behaviors (Oketch et al., 2023; Kenny et al., 2020). The situation is further compounded by climate-induced vulnerabilities common in arid and semi-arid lands (ASALs), including limited access to clean drinking water and increased exposure to zoonotic diseases (Kaoga, 2021; WHO, 2019). Collectively, these structural, environmental, and socio-cultural challenges hinder effective healthcare delivery and lead to poor health outcomes among the Maasai and other pastoralist groups. The past studies highlight critical study gaps that provided the impetus to explore how stakeholder engagement, participatory communication, culturally appropriate messaging, and motivational strategies can be harnessed to inform, involve, and empower communities in co-creating health solutions. Therefore, this study sought to determine how advocacy communication can be effectively utilized to enhance community health among pastoralist populations, with a particular focus on the Maasai of Kajiado County.

THEORETICAL FRAMEWORK

This study was guided by the social mobilization approach (SMA) of participatory communication. Social mobilization is an approach in participatory communication which involves trying to organize many people into

performing deeds and comportments that execute a net cost on each person who conforms and delivers trifling mutual subsidy (Coleman, 2023; Zhang, 2024). Social mobilization encompasses stimulating people to execute conducts that predominantly profit other people. Ideally, this means that the connotation and tenacity of social mobilization is primarily social. In other words, social mobilization can magnify the usefulness of other influencing moralities like observance to social medians, public assurances, and social culpability among others (Coleman, 2023).

It emphasizes collective participation, which is essential when addressing health challenges that require behavioral change across the community. Stakeholder engagement strategies align with SMA because they involve aligning health priorities with community needs through inclusive dialogue and participation. By encouraging collective ownership of health communication processes, social mobilization fosters a collaborative environment where policy-makers, health workers, and community members co-create solutions tailored to the local context (Ng'ang'a et al., 2021).

Furthermore, the SMA framework explains the utility of community participation methods in addressing entrenched health issues like poor hygiene, nutrition, and lifestyle practices. The theory suggests that when individuals see others within their social networks embracing healthier behaviors, they are more likely to do the same (Albertus & Schouela, 2024). This is particularly relevant to the determination of effective community participation methods. The participatory ethos of SMA promotes the use of culturally sensitive approaches and local structures such as elders' councils or women's groups that can mobilize support and commitment from within the Maasai community.

LITERATURE REVIEW

Audience Motivation Strategies that can lead to Community Participatory Decision-Making on Health Issues

Baxter et al. (2023) reviewed 44 studies on audience motivation and health in the UK, finding that limited resources weaken community capacity for participation. They emphasized innovative strategies for engagement and noted that positive community–organization relations foster trust and cultural change. However, reliance on secondary data created a methodological gap, which this study addresses through primary data.

Nasr-Azadani et al. (2022) synthesized 249 studies in the US and showed that reciprocal donor–beneficiary relations and project visualization enhance collaboration, address cultural barriers, and improve poverty alleviation. Yet, their project-focused lens introduced a conceptual gap, which the current study fills by examining advocacy communication in health.

Watson et al. (2024) reviewed 21 studies on youth engagement in the US, finding that incentives, strong relationships, and respect for autonomy improve participation and decision-making. Despite these insights, the focus on youth motivation and secondary data revealed a methodological gap addressed in this study.

Correia et al. (2023) used mixed methods in Portugal, showing that literacy levels, direct invitations, and value alignment influenced citizen participation. While insightful, the study centered on government-driven participation, leaving a conceptual gap this study addresses in pastoralist contexts.

Brock et al. (2021) found in Canada that conflicting stakeholder interests and lack of role clarity undermine community projects. They stressed the need for indigenous autonomy, but reliance on secondary sources presented a methodological gap, which this study fills with primary data.

Akwataghibe et al. (2022) showed in Nigeria that open forums, community segmentation, and involvement of elders enhanced immunization uptake, though the focus on childhood immunization limited scope. This study broadens the perspective to multiple health issues.

Ankomah et al. (2024) reported in Ghana that community engagement at lower-level facilities improved healthcare delivery, health-seeking behavior, and professional motivation. However, sole reliance on qualitative interviews limited generalizability, a gap addressed here through mixed methods.

Tugendhaft et al. (2021) revealed in South Africa that communities prioritized curative over preventive care, while access was hindered by urban-centered facilities. Although they recommended mobile clinics, their focus groups and general population lens overlooked pastoralist needs. The present study addresses both gaps.

Odawa et al. (2024) found in Kenya that community involvement in HIV/AIDS projects enhanced ownership, accountability, and alignment with local needs. Yet, the HIV-specific focus created a contextual gap, which this study expands to broader health issues.

Naanyu et al. (2023) showed that poverty, peer support, and Health Information Technology shaped hypertension management in Kenya. While valuable, the narrow disease focus introduced a contextual gap, addressed here through advocacy communication for general community health.

Strategies for community participation on health issues

Collective decision-making in terms of community participation is what could bring a major difference in the improvement of community health among the different communities of Kenya. There is therefore a need to be conversant with the communication strategies that would best play a role in ensuring that the whole community takes part in policy and decision-making on various health issues plaguing them.

Health communication campaigns

Health communication campaigns are arguably the most utilized and effective method for spreading public health messages, especially to endorse disease prevention and generally, health promotion and wellness (Kim, Singhal & Kreps, 2014:167). The Institute of Medicine agrees that health communication campaigns manage to organize messages for a diverse audience in one of three ways. These include:

- a) Catering to the common denominator within the audience.
- b) Creating a central message and then later making systematic adjustments to better reach a given audience segment while at the same time retaining the same central message.
- c) Creating different messages for different audience segments.

Additionally, health communication campaigns emphasize the importance of strategic planning. This includes a variety of steps meant to ensure a well-developed message has been communicated at the end of the day (Kim et al 2014:169). They include:

- a) Reviewing background information to define what the problem is and who exactly is affected by that problem.
- b) Setting communication objectives and formulating a plan that meets the wanted outcome.
- c) Analyse your target audience by determining what defines them. That is, establish what their interests are, their attitudes and beliefs.
- d) Selecting channels of communication by relating them to what will most effectively reach your target audience.
- e) Developing message concepts to determine understanding, acceptance and a particular reaction to that message.
- f) Implementing communication with a carefully selected audience and monitoring reactions to the message.
- g) Assessing the outcome and evaluating the effectiveness of the campaign and taking care to note if any changes need to be made.

Health communication channels

Entertainment media- Using the entertainment industry can be a very effective platform in advocating health information and education is a communication strategy that has become increasingly popular (Croucher 2016:188). The most commonly used and utilized strategy is for health communication professionals to create partnerships with different content creators so that messages on public health can be incorporated within the plot of whatever content is being produced.

Social Marketing- Media advocacy uses strategic mass media tools combined with a widespread organization to advocate for healthy public policies (Croucher 2016: 191). This can be inclusive of the use of text messaging and email meant to spread messages from one person to another and using social networking venues and platforms to promote health information to a wider range audience. As technology advances, platforms for health communication through media advocacy keep on expanding too.

Interpersonal Communication- Health Communication strongly relies on firm interpersonal communication to influence health decisions and behaviours. Most important of these relationships as pointed out by Croucher (2016: 192), are the connection and interaction between an individual and their health care providers like a therapist for instance and an individual's social support system like family, friends and the community at large. Such connections can positively influence the individual's decisions to make healthy ones. Patients or even community members who will greatly benefit from the formulated health communication messages are more prone to listen and adhere to these messages if they feel emotionally invested in the situation. If they feel they understand what is being said, then they are more prone to make objective decisions based on the information heard.

Communication and the functionality of community health committees

Health committees play a critical role in collecting community-level data through health volunteers who monitor and evaluate health activities. They also mobilize residents to participate in community dialogue forums, which provide opportunities for assessing information and developing participatory strategies for promoting healthy behavior. Communication is central to these processes, as it facilitates effective service delivery, improves patient satisfaction, and ensures the smooth flow of information between health facilities and the community (Mpembeni et al., 2015).

However, poor communication often undermines organizational change. Sakeah et al. (2021) argue that when communication across management levels is weak, changes are poorly received, leading to rumors, resistance, and negative cultural reactions. Despite evidence showing that internal communication strongly influences employee performance and attitudes, it is frequently underutilized as a management tool. Effective communication, by contrast, enhances self-motivation, cooperation, and task completion, while breakdowns create stress, conflict, and demoralization within health organizations (Karuga, 2019). Studies further show that most employees attribute poor performance to inadequate communication and teamwork (Holo, 2012; EASHW, 2010).

Karuga et al. (2019) also highlight the lack of investment in communication infrastructure, such as digital tools, within health facilities and the Ministry of Health. This disconnect hinders the effectiveness of advocacy communication in regions such as Kajiado, where improved technology could enhance outreach and health service delivery among Maasai communities. Limited funding and poor time management further complicate communication, weakening coordination across county, sub-county, and community health teams.

Communication in community health can take diverse forms, including barazas, dialogue days, chalkboards, formal and informal meetings, and monthly forums between health workers and community members. Yet, participation remains inconsistent. Karuga et al. (2019) found that low attendance at dialogue sessions and neglect of community health committees in decision-making processes reduced motivation and hindered coordination.

Community health committees composition and role

Health committees across East African countries share broadly similar roles, though specific structures vary by national health policies. Typically, they comprise 9–15 members drawn from both healthcare workers and community representatives, with leadership roles such as chairperson, secretary, treasurer, and often two co-chairs (male and female) to ensure gender balance. The effectiveness of these committees is strongly influenced by the credibility, skills, and influence of members, since community trust is critical for the acceptance of health initiatives (Loewenson et al., 2014).

For inclusivity, committees should reflect the wider community, particularly in terms of gender and representation of marginalized groups. Karuga et al. (2019) emphasize the importance of women's participation, while Loewenson et al. (2014) note that member selection—whether by election, appointment, or recruitment—shapes how well committees address local needs. Including influential or resourceful individuals can also strengthen decision-making and negotiation capacity. A diverse composition fosters innovation and better management, ultimately improving committee performance.

In Kenya, committees usually consist of 11–13 members, selected to represent different sectors such as women's groups, faith-based organizations, youth, and persons with disabilities (Ministry of Health, 2017). Their effectiveness depends not only on representation but also on training and expertise. Competence in planning, program implementation, monitoring, data management, problem-solving, and priority-setting is essential for ensuring quality health services and meeting community needs.

METHODOLOGY

Research Design and Research Paradigm

The convergent parallel approach was ideal for addressing the multidimensional nature of community health issues among pastoralist populations, which often intersect with cultural, environmental, and structural variables. Quantitative methods were instrumental in capturing the prevalence of health issues, communication channel preferences, and patterns of stakeholder engagement. In contrast, qualitative methods revealed the contextual realities such as cultural norms, mobility challenges, and trust issues that influence how advocacy messages are received. As Patton (2015: 14) notes, qualitative inquiry is especially effective in uncovering the meaning people attach to their experiences, which is vital in crafting culturally responsive health communication strategies. Together, these methods enabled a comprehensive understanding of both the "what" and the "why" behind the phenomena under investigation (Greene, Caracelli, & Graham, 1989: 256).

Despite its strengths, the mixed-methods approach presented challenges that were carefully considered. One of the key challenges was ensuring the integration of findings from two different data sets in a way that maintains methodological rigor. According to Teddlie and Tashakkori (2009, p. 283), mixed-method research demands a high level of expertise and careful planning to align sampling procedures, timelines, and data integration strategies. Another potential limitation is the resource-intensive nature of conducting both qualitative and quantitative research concurrently, particularly in remote pastoralist settings where accessibility and participant availability may be constrained. Nonetheless, these challenges were mitigated through meticulous research planning, pretesting of instruments, and phased data collection, ensuring the reliability and contextual relevance of the study's findings (Johnson, Onwuegbuzie, & Turner, 2007, p. 120).

In this study, the research paradigm adopted was the interpretivism paradigm which is ontologically relativist. This is because the study interpreted the meanings that were found after collecting and analyzing data and the different perspectives that were presented by the respondents.

Sampling and sampling technique and sample size

This study employed a combination of purposive sampling and simple random sampling to select participants for both qualitative and quantitative components. The use of multiple sampling strategies ensured that the study not only captured rich and relevant data but also upheld scientific rigor in selecting representative units.

For the qualitative component, the study collected data through Focus Group Discussions (FGDs) and open-ended sections of the questionnaire. The FGDs comprised grassroots community leaders, with each group structured to have 6–8 members. These participants were selected using purposive sampling due to their significant roles within the community. As community leaders, they possess in-depth understanding of the local context, particularly regarding health-related beliefs, cultural attitudes, and behavioral practices among the Maasai. This approach allowed the researcher to intentionally select information-rich cases that would provide nuanced insights essential to the study objectives. Their consistent interaction with residents and involvement in local governance, advocacy, and policy influence made them ideal informants, enhancing the depth and relevance of the data collected.

For the quantitative aspect, the study focused on questionnaire responses collected from selected community health units. Kajiado County hosts 126 recognized community health units, and using Yamane's formula for small populations (below 400), a sample size of 96 units was calculated to ensure scientific rigor in representation (Olonite 2022:1). These 96 units were then selected through simple random sampling using the lottery method. In this process, all 126 health units were assigned numbers, written on individual folded pieces of paper, and shuffled thoroughly in a container. The researcher drew 96 papers, ensuring that each unit had an equal chance of selection, thereby minimizing selection bias and ensuring geographical and institutional representation across the county.

From each of the 96 randomly selected community health units, three departmental heads were purposively sampled, yielding a total of 288 respondents. This use of purposive sampling within a random sampling framework ensured a balance between representativeness and relevance. While the random sampling guaranteed unbiased selection of units across Kajiado County, the purposive selection of departmental heads ensured that the information collected was contextually rich, relevant, and drawn from the most knowledgeable and authoritative personnel. Therefore, this combined sampling strategy enhanced the study's ability to produce findings that are both generalizable across health units and deeply insightful on the cultural and administrative nuances of health service delivery.

The investigator of this study utilized the purposive sampling method to identify the grassroots community leaders who participated in the FGDs. The sampling method was purposive because the researcher was only interested in those community members who are leaders.

Generally, in the Maasai community, men and women do not mix in gatherings where discussions will be involved. If they are mixed, you will find women not contributing to the discussion at all because of the cultural notion that women should be submissive and in the presence of men, they should be quiet. With this in mind, the researcher separated the respondents, hence having one FGD for male community leaders between 6-8 and another FGD for female community leaders between 6-8 in every sub-county. Thus, the total number of FGDs was 10 (2 in each of the five sub-counties of Kajiado County). These FGDs of 6-8 available members were constituted from the categories presented in Table 2.

Further, quantitative data was obtained through the close-ended section of the questionnaire that was administered to the department heads in each of the sampled 96 community health units in Kajiado County. The departmental heads as earlier mentioned were purposively sampled because of their position in the health units, giving a total of 288 respondents.

To calculate the sample size for this study, the researcher adopted Yamane's (1967:1) formula. The calculation below, based on the 126 community health units, demonstrates how the sample size was arrived at:

$$n = N / [1 + Ne^2]$$

Where, e=Sampling Deviation, n=Sample Size, N=Population Size, e=0.05(deviation).

N=126 community health units

$$n = 126 / [1 + 126 \times 0.05^2]$$

$$126/1+126 \times 0.0025$$

$$126/1+ 0.315$$

$$126/1.315= 95.82$$

N= 96 (sampled health units)

These 96 health units, were selected using the lottery method of simple random sampling as earlier explained.

This study targeted the departmental heads of outpatient, pharmacy and laboratory departments in each of the 96 sampled units. Departmental heads in each community health unit were purposively selected by their leadership positions. This meant that in every community health unit, the researcher had three respondents. In total, therefore, the study had 288 respondents which served as the total sample size for the study (96x3) as shown in Table 1.

Table 1 Sample Size for Questionnaire Respondents

Total community health units in Kajiado County	Sampled size of community health units via Yamane's Formula	The study sample size	Total number of respondents
126	96	96 x 3 health professionals	288

To obtain qualitative data, the study sampled 6-8 members for each FGD based on gender. These included two FGDs from each of the five sub-counties of Kajiado: East, west, North, South and Central providing a total of 10 FGDs.

Table is a depiction of the grassroots community leaders found in Kajiado County.

Table 2 Constitution of the FGD

	Representing Male	Representing Female
1.	'Nyumba Kumi' leader	Community health educator
2.	Clan elder	Administrative leader
3.	Chief	Women community leader
4.	Assistant chief	Women social group leader
5.	Community health worker	Traditional birth attendant
6.	Religious leader	Religious leader
7.	Nominated or elected local leader (village elder)	Nominated or elected local leader (village elder)
8.	Traditional herbalist	Traditional herbalist
Total	8 members	8 members

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Data Collection

The collection of data is defined as the process of systematic gathering of measurements or observations. Data collection instruments or tools are those strategies that are utilized by the researcher to enable them to gather data from the field.

The qualitative data for this study was obtained from two key sources: the departmental heads of the sampled community health units in Kajiado County and selected grassroots community leaders. To collect this data, the researcher employed Focus Group Discussions (FGDs) for the community leaders and included open-ended questions in the structured questionnaires administered to departmental heads. This dual approach allowed the study to tap into both experiential narratives and professional insights, enriching the depth and contextual relevance of the findings.

The choice of FGDs over other qualitative methods, such as individual interviews, was deliberate. FGDs are particularly effective in eliciting shared views, uncovering community norms, and generating rich discussions on culturally rooted health beliefs and practices. Given the communal nature of the Maasai society and the collective influence of its leaders on community health choices, FGDs provided an environment that encouraged open dialogue and the exploration of consensus and divergence on key issues. In contrast to interviews, which tend to focus on individual perspectives, FGDs facilitated interaction among participants, enabling the researcher to capture the dynamics of group reasoning and social influence, which are essential in understanding health behaviors shaped by culture and community values.

For departmental heads of health units, qualitative insights were gathered through open-ended questions embedded in the structured questionnaire. This approach allowed participants to elaborate on issues beyond the closed-ended items, offering explanations, contextual background, and nuanced opinions. The decision to use open-ended questions, rather than conducting in-depth interviews, was guided by practical considerations, such as geographic dispersion. These open responses served as a complementary data source, ensuring that the study did not merely quantify perspectives but also understood the 'why' behind trends and practices in health service delivery.

By combining FGDs with open-ended questionnaire responses, the study leveraged the strengths of both structured and exploratory data collection techniques. FGDs provided interactional data rich in cultural insights, while the open-ended responses gave voice to individual professional experiences within health facilities. This methodological combination was well aligned with the study's objectives. The inclusion of multiple qualitative sources supported triangulation, enhancing the credibility, depth, and robustness of the data.

To collect primary quantitative data, the researcher used questionnaires. The questionnaires were issued to the department heads from the sampled community health units. The questionnaires had two sections: one section for a Likert scale to enable the researcher to collect quantitative data while the other one had open-ended questions for qualitative data. The researcher administered the questionnaires herself and ensured that she explained to the respondents individually about the informed consent so that they knew what was expected of them. Furthermore, the study used primary and secondary data. The primary data used was generated from the views of the respondents while secondary data was obtained from materials from the Ministry of Health regarding the health situation in Kajiado County.

Ethical Clearance

Ethical standards were adhered to throughout the research process to safeguard the dignity, rights, and well-being of all participants. Before the commencement of the study, the researcher sought ethical approval from the Ethics Review Committee of the University of South Africa. This ensured that the research conformed to institutional standards for research involving human subjects. The researcher then sought authorization from the

Ministry of Health in Nairobi, Kenya, and consent from the administrative heads of the community health units within Kajiado County.

FINDINGS

Community Participation Methods to Address Health Challenges in determining strategies that can lead to community participation methods.

This section presents both descriptive findings and thematic analysis of the findings that explain strategies that would best address the identified health challenges among the Maasai community of Kajiado county.

Health Challenges in Kajiado County

Figure 1 presents the reported prevalence of key health challenges affecting the Maasai community in Kajiado County. Nutrition-related issues emerged as the most prevalent, reported by 30% of respondents, followed by antenatal care-related challenges at 21%. Dysentery was reported by 18%, while trachoma and fistula were each identified by 14% of respondents. Reproductive health issues were the least cited, accounting for only 3%. The high incidence of nutrition and antenatal care-related problems suggests gaps in preventive health education, access to essential maternal and child health services, and availability of clean water and sanitation. These findings highlight the critical need for targeted health interventions addressing nutrition and maternal health within the community.

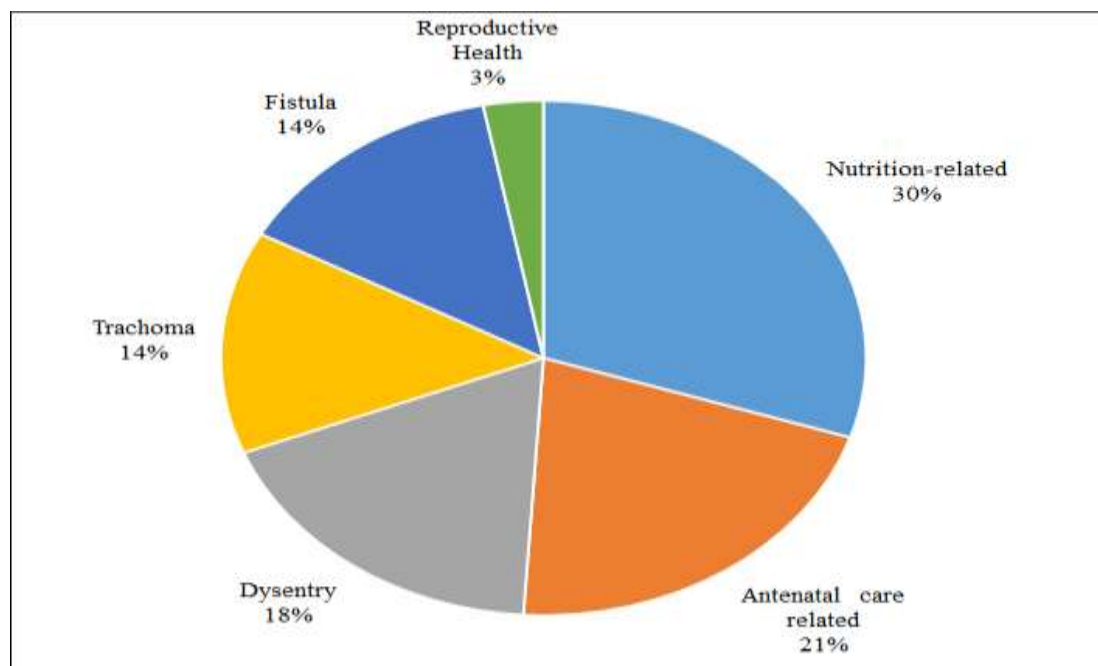


Figure 1 Health Challenges in Kajiado County

The high prevalence of nutrition-related and antenatal care-related issues reported in Kajiado County reflects systemic barriers highlighted by Domokwang (2022) and Kimaru (2023), including remote living conditions, inadequate infrastructure, and limited availability of qualified healthcare providers. Similarly, the presence of dysentery and trachoma corresponds with the sanitation deficits noted by Mulatya et al. (2021) and Belay et al. (2022), where access to improved sanitation remains low, especially in arid and semi-arid areas. These results affirm Waruguru et al.'s (2021) assertion that pastoralist populations remain underserved by Kenya's centralized healthcare model, reinforcing the need for community-based interventions as recommended by WHO (2024).

Community Participation in Decision-Making

Respondents were asked to indicate whether community participation in decision-making on matters concerning health is enhanced by the adoption of appropriate communication strategies. Figure 2 illustrates how the

responses were distributed. The figure shows that 32% of the respondents agreed and a further 28% strongly agreed that adoption of appropriate communication strategies enhanced community participation in matters concerning their health. However, 28% of the respondents disagreed, and 12% were not sure.

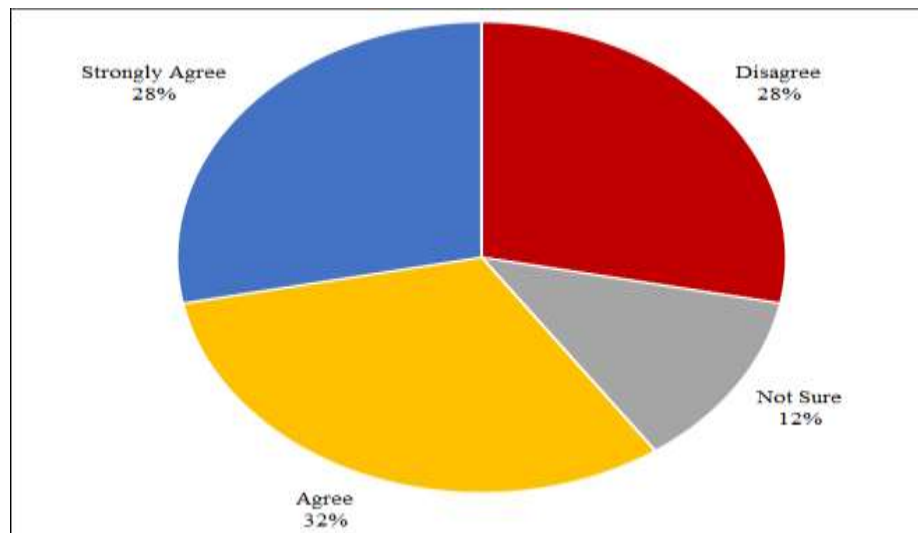


Figure 2 Community Participation in Decision-Making on Matters Concerning Health is enhanced by the Adoption of Appropriate Communication Strategies

As is evident from the findings, a majority of respondents indicated that appropriate communication strategies enhance community participation in health matters, which supports Dada's (2023) position that community health is most effective when it is accepted and supported through participatory communication. The finding also affirms Salve et al. (2023) and DeHaven et al.'s (2021) emphasis of the role of community health workers in enhancing localized, inclusive communication for better health outcomes. However, the fact that 28% disagreed and 12% were unsure highlights persistent communication barriers, as also noted by Wafula et al. (2023) and Schilling and Werland (2023), who report minimal integration and poor communication between the health system and marginalized groups like pastoralists. Thus, while the findings affirm the positive role of communication in theory, they also align with literature showing the challenges of practical implementation in Kenya's diverse and often underserved communities.

Thematic analysis of qualitative data yielded three overarching themes: Participative Communication, Channel Diversity, and Use of Role-Models as summarised in table 6.

Table 3 Key Themes of Community Participation Methods to Address Health Challenges

Verbatim Responses	Code	Sub-theme	Theme
Respondent 137: "When communication involves community members, it flows very well in the community and it gives room for argument hence proper understanding e.g. why trachoma tablets cause nausea and sometimes vomiting."	Community involvement	Consensus	Participative communication
Respondent 157: "Participation opens up their mind into thinking outside the box and collectively think of a way of dealing with the identified challenges."	Collective thinking	Consensus	Participative communication
Respondent 229: "Participation ensures that everyone has a chance to give his or her opinion. This way communication is all round and not biased."	Give opinion	Consensus	Participative communication

Respondent 240: “Participation ensures everyone is in agreement with what is being said and are on the same page.”	Agreement	Consensus	Participative communication
Respondent 2, FGD A, Sub-County 2: “A lot of talking to people individually and in groups.”	Talk to people	Individualised communication	Individualised communication
Respondent 4, FGD A, Sub-County 1: “My observation is that most methods involve talking to people. Digital mmm... not sure unless we consider TV programs.”	Talking to people	Individualised communication	Individualised communication
Respondent 4, FGD B, Sub-County 2: “Talking and persuading individuals who are affected.”	Persuading individuals	Individualised communication	Individualised communication
Respondent 3, FGD A, Sub-County 4: “Explaining different diseases and how to avoid them.”	Explaining diseases	Individualised communication	Individualised communication
Respondent 167: “It brings a sense of ownership and appreciation thus becomes easy for the community to understand the message being put across.”	Sense of ownership	Promotion of ownership	Promotion of ownership
Respondent 177: “Leads to empowerment of the community members since they are included. Through empowerment, the message flows and they have a platform to give their insights.”	Empowerment	Promotion of ownership	Promotion of ownership
Respondent 189: “Makes them appreciate more being involved thus work very hard towards getting a solution.”	Being involved	Promotion of ownership	Promotion of ownership
Respondent 254: “It makes community members be more open on the issues affecting them. They feel they are a part of the solution and hence do not hold back.”	Feel part of solution	Promotion of ownership	Promotion of ownership
Respondent 1, FGD A, Sub-County 5: “The health experts are also invited to talk to people during the chief’s barazas. Such an opportunity serves as an awareness-creation session.”	Barazas	Community forums	Channel diversity
Respondent 1, FGD B, Sub-County 4: “Eh... they’re also invited in churches for public education.”	Churches	Community forums	Channel diversity
Respondent 2, FGD B, Sub-County 5: “There is the use of reading materials such as pamphlets and fliers that are given to children in schools or patients who visit health clinics.”	Schools / Health clinics	Community forums	Channel diversity
Respondent 8, FGD A, Sub-County 3: “Organized workshops and seminars where people are taught is also an approach used.”	Workshops	Community forums	Channel diversity

Theme #1: Participative Communication

The theme of participative communication manifested through three sub-themes. The first sub-theme was Inclusive Communication whereby community participation was seen to facilitate clear and unbiased communication, ensuring all members are heard and understood. Respondents emphasized that when everyone is involved in the communication process, it creates clarity, reduces misinformation, and enhances collective comprehension of health issues. Participation creates a platform for dialogue, critical thinking, and agreement, which are essential for addressing health challenges. Through open and interactive engagement, communities

are better positioned to understand causes, implications, and possible solutions to health problems. The following are verbatim expressions:

“When communication involves community members, it flows very well in the community and it gives room for argument hence proper understanding e.g. why trachoma tablets cause nausea and sometimes vomiting.” (Respondent 137)

“Participation opens up their mind into thinking outside the box and collectively think of a way of dealing with the identified challenges.” (Respondent 157)

“Participation ensures that everyone has a chance to give his or her opinion. This way communication is all round and not biased.” (Respondent 229)

“Participation ensures everyone is in agreement with what is being said and are on the same page.” (Respondent 240)

From the foregoing findings, it is clear that respondents’ emphasis on inclusive communication that fosters clarity, mutual understanding, and critical thinking aligns with SMA’s focus on collective participation and community-driven dialogue as essential for addressing health challenges as postulated by its proponents such as Zhang (2024). The idea that participation enhances agreement and reduces misinformation mirrors Albertus and Schouela’s (2024) discussion of SMA’s principle of connectedness and accountability, where individuals are motivated by shared goals and social responsibility. Additionally, the respondents’ recognition of participation as a platform for solution-oriented discussions supports Ng’ang’a et al.’s (2021) perspectives on the SMA’s emphasis on culturally grounded stakeholder engagement and collaborative decision-making. Thus, the findings affirm Lan et al.’s (2025) argument that the SMA’s utility is in fostering inclusive and effective advocacy communication that inspires behavioral change and collective health action within marginalized communities such as the Maasai.

The second sub-theme was individualized communication which emerged as a central method of health advocacy among the Maasai, where health workers and community health volunteers (CHVs) engage directly with individuals or small groups. This approach enhances understanding, allows for tailored messaging, and builds trust within the community. Through personal conversations, persuasion, and question-answer sessions, health educators are able to break down complex health issues into relatable and actionable advice. This personalized approach has proven effective in influencing attitudes and addressing culturally sensitive issues that might not be openly discussed in larger forums as captured in the following verbatim statements:

“A lot of talking to people individually and in groups” (Respondent 2, FGD A, Sub-County 2)

“My observation is that most methods involve talking to people. Digital mmm... not sure unless we consider TV programs” (Respondent 4, FGD A, Sub- County 1)

“Talking and persuading individuals who are affected” (Respondent 4, FGD B, Sub- County 2)

“Explaining different diseases and how to avoid them” (Respondent 3, FGD A, Sub- County 4)

Another dominant sub-theme is the role of participation in empowering communities and cultivating ownership of health interventions. Respondents highlighted that being part of the decision-making and problem-solving process makes the community more committed and proactive. Participation builds confidence, provides space for local insights, and enhances motivation to act. It transforms community members from passive recipients of aid to active stakeholders in their own health and well-being, ultimately improving the uptake and sustainability of health solutions.

“It brings a sense of ownership and appreciation thus becomes easy for the community to understand the message being put across.” (Respondent 167)

“Leads to empowerment of the community members since they are included. Through empowerment, the message flows and they have a platform to give their insights.” (Respondent 177)

“Makes them appreciate more being involved thus work very hard towards getting a solution.” (Respondent 189)

“It makes community members be more open on the issues affecting them. They feel they are a part of the solution and hence do not hold back.” (Respondent 254)

The findings show that respondents’ emphasis on one-on-one and small group engagements by health workers and CHVs reflects the value of tailored, culturally sensitive messaging that builds trust and enhances comprehension. This agrees with the core aspects of personalisation inherent in social mobilization principles as put forth by Cavdar Aksoy et al. (2021). The use of direct conversations and persuasion to address complex or sensitive health topics reflect what Onuoha et al. (2024) describe as essential in pastoralist communities like the Maasai, where trust and cultural relevance are key to influencing behavior. Furthermore, the respondents’ reliance on personal dialogue over digital methods confirms Li et al. (2021) and Awoyemi et al.’s (2025) assertion that face-to-face engagement is often more effective in generating collaboration and behavioral change, particularly in marginalized or rural settings.

Theme #2: Channel Diversity

Channel diversity manifested the various public forums used such as Barazas (public gatherings), churches, schools, and clinics which respondents identified as influential advocacy platforms that bring together community members for structured health education sessions. These forums not only legitimize the health messages being conveyed – since they are often led or endorsed by authority figures—but also provide repeated exposure to important health concepts. The involvement of health professionals in these forums boosts the credibility of the information shared, leading to increased knowledge and awareness among community members. Educational materials such as pamphlets, fliers, and posters complement these gatherings, especially in school and clinic settings. This was apparent in the following verbatim excerpts:

“The health experts are also invited to talk to people during the chief’s barazas. Such an opportunity serves as an awareness-creation session” (Respondent 1, FGD A, Sub- County 5)

“There is the use of reading materials such as pamphlets and fliers that are given to children in schools or patients who visit health clinics” (Respondent 2, FGD B, Sub-County 5)

“Eh... they’re also invited in churches for public education” (Respondent 1, FGD B, Sub- County 4)

“Organized workshops and seminars where people are taught is also an approach used” (Respondent 8, FGD A, Sub- County 3)

From the analysis, it can be inferred that respondents affirmed that diverse forums such as barazas, churches, schools, and clinics serve as credible and repeated avenues for health education and behavior change. This aligns with Matusitz (2022), who emphasizes the effectiveness of campaigns targeting multiple audiences through structured and repeated messaging. Similarly, the role of community mobilization highlighted by Kinyua (2023) and Corbin et al. (2021) is evident in how local forums unite community members toward shared health goals. The involvement of health professionals in these forums resonates with findings by Willis et al. (2023), who stress the importance of trusted sources in health communication. Moreover, this study’s emphasis on structured and repeated exposure aligns with Hong’s (2023) conclusion that proactive, coherent communication builds informed decision-making. Also, the credibility of channels and inclusivity in messaging reflect Ezeaka et al.’s (2025) assertion that effective advocacy is grounded in trust, cultural sensitivity, and grassroots engagement, all of which were evident in the Maasai community's experience.

Theme # 3: Use of Role Models

Respondents observed that role modeling and live demonstrations are highly effective strategies in influencing health-related behavior change among the Maasai. Health educators and community leaders not only teach but

also embody the behaviors they advocate for, such as using latrines, boiling milk, and washing hands. These visible acts serve as persuasive non-verbal communication that reinforces messages shared verbally. Practical demonstrations make abstract health concepts tangible and ensure community members can replicate the practices in their homes. The use of visual aids – posters, pictures, and live sessions – further enhances understanding, especially in communities with low literacy levels. The following are verbatim examples:

“People look at us and emulate us such as practices of boiling milk, using latrines, and washing hands” (Respondent 1, FGD A, Sub- County 2)

“Demonstrations e.g. How to wash hands, use a latrine, use and dispose of used sanitary pads for the girl” (Respondent 4, FGD B, Sub-County 4)

“I have seen the facilitators from the Ministry of Health directly involved in building latrines” (Respondent 7, FGD A, Sub-County 1)

“Being role models within communities is also a strategy” (Respondent 3, FGD B, Sub-County 4)

The findings agree with Loewenson et al. (2014) who emphasize the importance of using respected, trusted, and influential community members to drive behavior change in health interventions. The role modeling and live demonstrations cited by respondents such as health educators visibly engaging in practices like boiling milk, washing hands, and building latrines affirms the notion that community health committee members must embody the values and behaviors they promote to gain trust and ensure effectiveness.

DISCUSSION

Audience motivation strategies that can lead to community participatory decision-making on health issues affecting the Maasai of Kajiado County

This objective helps in finding out the audience motivation strategies that can lead to community participatory decision-making on health issues affecting the Maasai of Kajiado County. Conclusion was drawn that interactive

health education, use of trusted local structures, demonstrations and use of visual tools, and role modelling health behavior constitute the audience motivation strategies that promote community participatory decision making regarding the health issues that affect them.

This study found out that both health practitioners and community leaders are actively involved in including community members in the decision-making and policy-making process, hence making them part of the solution. The grassroots community leaders elaborated that awareness creation in the first place is very important because this is what helps in the dissemination of important messages and as such, when information is shared, there is a greater chance that attitude change will occur. This argument has been backed up by the elaboration likelihood model (ELM) as established by Petty and Cacioppo (1986: 132) which argues, that persuasion communication is key in shifting the attitudes of the recipient of a message (Pears 2018:12). Hence, the message itself should be very deliberate because the way it has been packaged and delivered will heavily determine whether or not the recipient of that message will readily accept and internalize it or not. That’s why the social mobilization approach as presented by Rogers et al (2017:41) insists on making the message personal, holding the community accountable and also being relevant because the connection between people’s identities and their behaviour has to be leveraged given how often people hold many competing identities.

In this study, therefore, it was important to establish whether there is inclusivity of other community members as far as making decisions and policies on the improvement of health in their locality is concerned. The most common communication strategies that the grassroots leaders use to encourage community participation in making decisions and finding solutions in relation to the health issues affecting them include holding chief baraza meetings as often as possible, conducting public education and awareness creation workshops and also talking constantly about the identified health issues and giving educative information on preventive measures in radio and TV programmes. Visual aids where they use videos and films to talk about the health issues and hence create

more awareness of them are also used. Edutainment is also heavily embraced, given how it easily captures the attention and interest of its audience. As ELM purports, motivation is key in persuading your audience to pay key attention to your message. It is vital that the recipient of your message feels compelled and interested enough to listen to you because that is the first step towards attitude and behaviour change concerning the use of appropriate advocacy communication methods and strategies.

Further, the study also established that the Maasai community has in the recent past been introduced to technology in terms of televisions and phones, thus, there is a much better way of accessing information from the healthcare sector. It was found that the advocacy communication had a significant impact on the changes in the Maasai community health because when there is an increase in such information then the same leads to an increase in behavioural change and more community members are included in policy and decision making, the more aggressive they become towards achieving change and better health practice.

In support of the current findings; the same were in agreement with the European Centre for Disease Prevention and Control (2021: 2), the espousal of a health advocacy prototype or archetype can easily concentrate on a scholastic facet where it ascertains incipient public health issues that necessitate action. Additionally, as Weinreich (1999:6) argued, any advocacy communication message should be developed based on a very well-thought-out and planned communication strategy. This is typically derived from a point of knowledge of behaviour change and communication theories as well as data that has been collected through audience research. If this was applied to the pastoral community in Kenya it would mean that the same would be more effective and efficient among the Maasai community which would go a long way in the enhancement of community health among the Maasai of Kajiado. The conclusions and findings of the study have agreed with some of the pioneering studies that were conducted years before this study.

Concerning advocacy communication, it is prudent to note that the owning of smartphones by most of the members of the Maasai community will enhance the direct communication to the members of the community which will go a long way in guaranteeing that there is improvement in community health among pastoral communities in Kenya. This finding suggests that advocacy communication is much more effective and efficient in reaching the seemingly remote Maasai community members. It also means that when advocacy communication has been utilized and implemented carefully then the same has the potential to improve community health to a greater extent among members of the Maasai community in Kenya. Therefore, much more needs to be done by the government and other stakeholders to ensure that there is support and funding for those who are involved and those who are entrusted with the role and function of advocacy communication. There should be much more improvement and funding in areas that are also in connection to advocacy communication like civil education and community training concerning health matters. Other forms of development of the areas that are far from civilization are also necessary for better implementation for example the extension of electricity outreach to these areas and network connectivity should be spearheaded so that these efforts by the Ministry of Health can realize success and benefits.

In line with the social mobilization approach, it is an approach in participatory communication which involves making an effort to organize many people into performing behaviours that foist net costs on each individual and personnel who conforms and provide trifling collective benefits. Therefore, if the members of the community can come together and voluntarily participate in the communication efforts and practice the word of mouth during and after meetings with the members of the community health then it would mean that they will be much better placed to fight health challenges that may face the community in future. If there is a collective effort to participate in the communication process and the communication can reach all homesteads then it will be much easier and possible to leave the behaviours and habits that expose the members of the community to infections and diseases.

The findings also suggest that more members of the Maasai community continue to get connected to the national grid and as they continue to acquire communication devices such as phones and radios the same is a stride towards the right path because it will highly enable direct communication by the advocacy communication agents. The instructions and details for the meetings can be communicated much more efficiently when there is prior communication through a phone, television or radio.

RECOMMENDATION

When it comes to focusing on audience motivation strategies that are aimed at ensuring that community participation in decision making on health issues takes place, there must be a sense of engagement of the community. Strategies such as interactive health education, message transmission through trusted local structures, practical demonstrations and use of visual tools, and role modelling behavior. Therefore, the health officers should first address themselves and introduce themselves to allow the members of the community to present their issues and their problems before the health officers.

CONCLUSION

Concerning the audience motivation strategies that can lead to community participatory decision making which are brought about by the poor health issues affecting the Maasai community in Kajiado County, it was found that interactive health education, use of trusted local structures, demonstrations and use of visual tools, and role modelling behavior were salient themes. It was noted that communication strategies are directly connected to the cultural beliefs of the community. Some of these strategies include the direct traditional methods by use of the community elders, chiefs, traditional healers, midwives, youth leaders and herbalists.

The community is more directly connected to the elders of the community daily and they know where exactly to find them in case of need. Further, the elders of the community are known to make announcements and communicate occasionally in relation to the weather and other communications such as the changes in seasons and cultural events. This means that there is an element of conviction and trust amongst the community and the adherents of the elder's council in the community. This is one of the key persons or individuals who should be given the mandate and the responsibility to take the community and guide them when it comes to health communications information that the health officers would like to reach the community.

Further, the chiefs and traditional healers are revered by the members of the community and as such the trust accorded to them means that they influence or affect the decisions of the community to a significant extent and as such can pass across a message. Therefore, these are also individuals and groups that can be trained to pass across health-related communication or messages to the members of the community even when they are in their day-to-day goings-on so that people can alert a health crisis for example in case there is a challenge or an outbreak. The chiefs can display information on the notice board or call a meeting and advise the community on the changes in the health protocols and procedures, this would go a long way in ensuring the well-being of the community when it comes to health matters.

The traditional healers on the other hand can put out information among the affiliates of the civic especially persons who have come for healing. This means that they can disseminate information even when they are practising their skills. The fact that there is also an element of trust between the members of the community and the traditional healers then it means that they will take seriously and confidently the medical information that the healers will pass across to them.

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