Lived experiences of community health strategy coordinators during the COVID-19 pandemic response: An explorative qualitative study in Kiambu County, Kenya

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ABSTRACT

Introduction: The COVID-19 pandemic severely strained health systems worldwide, particularly in low-resource settings. In Kenya, community engagement led by Community Health Strategy Coordinators (CHSCs) was central to the national response. However, little is known about CHSCs' own experiences navigating these responsibilities. This study explored the lived experiences of all CHSCs in Kiambu County, Kenya, during the pandemic's peak. **Methods:** We conducted a 90-minute focus group discussion (FGD) with all twelve sub-county CHSCs in Kiambu County. The discussion was audio-recorded, transcribed verbatim, translated into English, and analyzed using reflexive thematic analysis to identify key experiences, perceptions of community responses, and system-level. gaps. **Results:** The FGD revealed four inter-related challenges: inadequate resources (particularly transport and personal protective equipment) that impeded service coverage; psychological distress and stigma, including trauma from handling COVID-19 deaths and rejection by community members and family; feelings of neglect and inequity stemming from perceived exclusion from government support and allowances; and community distrust, where inconsistent political role-modelling eroded adherence to guidelines and discouraged health-seeking. Fear of health facilities as COVID-19 hotspots further disrupted routine healthcare services. **Conclusion:** CHSCs sustained critical community response functions under extreme strain but felt under-resourced, stigmatized, and undervalued. Strengthening county-level preparedness requires equitable provision of PPE and transport support, routine psychosocial care for community health teams, and community co-designed communication strategies to rebuild trust. These findings underscore the pivotal role and vulnerability of CHSCs as the bridge between policy and household-level health action during crises.

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Introduction

In January 2020, the World Health Organization (WHO) declared coronavirus disease 2019 (COVID-19) a public health emergency of international concern [1], and by March 2020, it was classified as a pandemic [2]. Across Africa, 712,920 cases and 11,900 fatalities had been reported by July 27, 2020; in Kenya, 17,975 cases and 285 deaths had occurred [2]. Kiambu County initially had no cases in March 2020 [2], but by May 2020 ranked fourth nationally in reported infections [3].

To contain the rising COVID-19 caseload, the community health services were envisioned to underpin and complement the broader health system during COVID-19 [4]. Kenya's Level One structures provide household-level primary health care through close-to-community strategies [4,5], which are widely credited with improving service access and purported to move the country towards universal health coverage [6].

In Kiambu County, Community Health Service Coordinators (CHSCs) are the public health officers at the sub-county level who lead and coordinate community health services. CHSCs are salaried frontline supervisors attached to public facilities who mentor and train community health promoters (CHPs), oversee data quality, provide technical support, and link households to care. CHPs, who at the time of the study were called Community Health Volunteers (CHVs), are lay, community-based workers delivering household-level services such as health education, antenatal and postnatal follow-ups, chronic disease treatment support, case finding and referral, defaulter tracing, commodity distribution (e.g., condoms and soap), and basic community surveillance.

After Kenya's index case in March 2020, the government mandated two-week quarantines for incoming travellers, enforced curfews, and imposed movement restrictions in several regions [7,8]. This created a double burden: as COVID-19 surged, vulnerable populations struggled to access essential health services [8]. To accelerate containment and relieve the formal health system, the Ministry of Health tasked community health teams with contact tracing, community-based monitoring for suspected cases, and the continuation of routine household services [4]. Supplies, including medical masks, gloves, sanitizers, soap, cleaning materials, disposal bags, thermo-gun thermometers, airtime, internet bundles, and basic medical commodities, were to be provided to CHSCs and CHVs (at the time) to safely conduct these tasks. Ministry guidelines also specified psychological support for staff, but implementation was inconsistent.

The lived experiences of CHSCs, who were responsible for coordinating these extensive duties amid resource constraints, remain under-documented. Understanding their perspective is urgent, particularly in light of the Primary Health Care Act 2023, which seeks to achieve universal health coverage through community-level primary care [9].

Existing literature has highlighted the experiences of CHVs during COVID-19 [6,10], but little is known about CHSCs, the sub-county coordinators who bridge national policy and frontline implementation and influence supervision, resource allocation, and intersectoral coordination. Given this gap, our study aimed to explore CHSCs' experiences coordinating the community-level COVID-19 response in Kiambu County during the height of the pandemic. Specifically, we sought to understand how these coordinators experienced their roles, constraints, and available support while managing community health activities under unprecedented pressure. We also examined how they perceived community responses and care-seeking behaviours during periods of movement restriction, and what system-level facilitators and gaps they identified that could inform better preparedness and support for future health emergencies.

Methods

Study design

We adopted an exploratory phenomenological qualitative design to capture the lived experiences of CHSCs during the COVID-19 pandemic. The qualitative component was embedded within a larger quasi-experimental pre–post study that triangulated routine data from Kenya's Health Information Management System with qualitative findings from FGDs.

Our epistemological stance was pragmatism: to generate actionable insights for county practice, combined with a phenomenological orientation to attend closely to participants' lived experiences. Data were analysed using reflexive thematic analysis

following Braun and Clarke's approach, generating themes inductively and deductively from the data rather than testing *a priori* hypotheses [11].

Study setting and local context

The study took place in Kiambu County, central Kenya (area: 2,543.5 km²). The county borders Nairobi and Kajiado (south), Machakos (east), Murang'a (north/northeast), Nyandarua (northwest), and Nakuru (west). Kiambu had no recorded COVID-19 cases in March 2020, but by August 2020 had 777 cases, rising to 11,314 by August 2021 [12]. The County of Kiambu had a population of approximately 2,417,735 at the time [13]. During national movement restrictions, several Kiambu sub-counties, including Kikuyu, Limuru, Kabete, Kiambaa, Kiambu Town, Juja, Ruiru, and Thika Town, were classified within the Nairobi Metropolitan Area and subject to renewed lockdowns enforced by police roadblocks.

Study population and sampling

All twelve CHSCs in Kiambu County were invited (constituting a census sample) because they are the most senior officers coordinating community health services at the sub-county level. Their vantage point bridges CHPs/CHVs and county/national leadership, making them uniquely positioned to reflect on both frontline and systemic challenges. Rather than claiming numerical saturation, we followed the concept of information power, judging that the relevance and specificity of this entire population were sufficient for our exploratory aims.

Data collection

The FGD guide was drafted in English and refined by a sociologist from Mount Kenya University, Thika County, Kenya. Invitations were emailed by the County Department of Health with follow-up phone calls; and participation was voluntary. The discussion was held in June of 2021 in a private room within a health facility and lasted approximately 90 minutes.

The guide covered three domains:

1. Experiences coordinating community response during COVID-19 lockdowns.
2. Perceptions of community attitudes and behaviours.
3. Access to and continuity of health services during restrictions.

Example prompts included: "Please share your experiences during the COVID-19 lockdown. This is in relation to your duties, to your role as a community health strategy focal person."; "In your opinion, how did the community respond to the COVID-19 control measures?"; and "In your opinion, how did the COVID-19 control measures affect community access to the health facilities?".

The discussion was conducted in English and Kiswahili according to participant preference. Audio was transcribed verbatim, anonymized, and translated into English for shared coding and publication. A bilingual research assistant completed initial translation, and a second bilingual team member cross-checked a subset for fidelity. All participants provided written informed consent (including consent for audio recording and anonymised quotations). The FGD was facilitated by an experienced qualitative researcher (NW) and observed by a note taker (BK), both county health managers.

Reflexivity

All three analysts (MK, NW, PKJ) are county health staff (roles: research manager, qualitative researcher, researcher). Recognising potential insider positionality and power dynamics, the team engaged in reflexive journaling, explicitly bracketed pre-conceptions before analysis, encouraged dissenting viewpoints during coding meetings, and sought peer debriefing with a qualitative methods advisor outside the county.

Data management and analysis

The transcript was imported into MAXQDA 2020 for coding. Three analysts independently read and coded the transcript, iteratively refining an initial code set through reflexive engagement.

Our approach integrated both deductive and inductive strategies: theory-informed codes derived from the literature and tool development guided initial coding, and inductive analysis allowed new, data-driven categories to emerge and refine the framework.

We used a negotiated-agreement process to resolve differences and maintain an audit trail (versioned codebooks, memos, and decision logs). Themes were validated through double-coding, consensus meetings, and peer debriefing; preliminary themes were sense-checked informally with two CHSC colleagues not in the FGD for face validity (no new data introduced). Quotes are labelled Respondent#

and presented verbatim with minor ellipses for brevity; identifying sub-county details were removed to preserve anonymity.

We interpret "psychological trauma" as participants' descriptions of distress related to body handling, fear, and moral strain (not a clinical diagnosis) and "stigma" as enacted or anticipated social devaluation and avoidance of health workers, consistent with sociological usage.

Ethical approval

Ethical approval was obtained from the University of Eastern Africa, Baraton Research Ethics Committee (UEAB/REC/08/06/2020), with additional permission from the Kiambu County Department of Health. A debriefing session and formal referral pathways were offered to participants after the FGD.

Results

Participants

All twelve CHSCs in Kiambu County participated. Most were women (9/12, 75%), aged 35–55 years, with 8–22 years' experience as Public Health Officers. This breadth of seniority and tenure gave a county-wide, experienced perspective. Three overarching themes emerged:

Strained coordination under inadequate support (resources, psychological burden, stigma, and perceived government neglect)

Lack of resources impeded service delivery: The CHSCs reported a widespread sentiment of a lack of necessary resources for optimal service delivery. Participants repeatedly described self-funded transport across vast sub-counties and insufficient PPE, which impeded their capacity to reach clients in expansive regions. Even once contact was made with a client, the CHSCs relayed that they did not always have the necessary PPEs.

"… we were not able to access some areas because of travel and transport issues… we don't have utility vehicles, so we also have to use public transport. … they had hiked the fares… the ward is very, very vast and sometimes, like using a motorbike… I have to pay over five hundred…" (Respondent3)

"At the beginning, we were not being issued PPEs, so we had to buy them… even when the government chipped in, we were just given like four masks for a week." (Respondent 1)

"Transport was very high to access the working places. We could not make it on a daily basis because the transport was very high." (Respondent 7)

Psychological trauma and absence of psychosocial support ("Nobody cared"): The demanding nature of the job, with added responsibilities such as disposing of bodies of people who died of COVID-19, led to significant psychological trauma among the CHSCs. This emotional turmoil was rooted in the lack of support and recognition for their hard work and sympathizing with the plight of most of the community members. For some, working in the COVID isolation facilities and witnessing patient mortality left indelible mental anguish.

"And there is nobody who cares about your mental [health]… you know you are also a human being? You also have emotional needs. Nobody cared. So, I think there was also a gap there. Nobody took care of the public health departments, those who were dealing with those issues…Sometimes you feel like you know, you get to a point where you think this life is not worth it]…." (Respondent 6)

"…Nobody even cared to give us security… we were doing so much; I wish they had given a counsellor…"(Respondent 3)

This mental turmoil was dealt with by relying on colleagues and sharing their experiences amongst themselves and with their friends, since psychological help was not provided.

"Interviewer: How were you… how did you overcome these challenges?
Respondent 1: by talking to friends. You know some… spiritual, spiritual help. But on the part of the health department, nobody cared. Now, sometimes you would share, like amongst us we would talk, you know? 'How was it? How did you overcome?'" (Respondent 1)

Stigma from communities and families: CHSCs described being stigmatised by the communities they serve, which further impeded their work. They were frequently perceived as potential carriers of COVID-19 who might transmit infection, and this stigma extended into their personal lives, with some relatives distancing themselves and offering little support.

"We also had some challenges because the health workers were getting stigmatized by the community. Whereby, for example, in Tigoni, Kiambu COVID centre, the matatus could not carry anybody coming out of that centre of the hospital, whether staff or a patient." (Respondent 9)
"Even our relatives would tell you, 'You usually go to collect bodies? Don't come home. And you know they are your relatives, what do you do? So, you feel unwanted." (Respondent 1)

"There is no viewing of that body, you have to convince the family members… again, the cultures, so they are wondering how they will be buried without clothes? So sometimes they would rise against you… I remember one time the crowd became very violent…the crowd was surging up now. So, we had to call the security from within the hospital to come and give us backup." (Respondent3)

Feeling overlooked by the government: CHSCs expressed persistent disappointment at the limited recognition and remuneration for their expanded roles. They reported shortfalls in PPE and other essential supplies, including when manning roadblocks, and perceived exclusion or inequity in the allocation of risk allowances, leaving them feeling overlooked by the government.

"The COVID package that came, or is it a relief that came through his Excellency's directive on the pay and also the allowance we received as health workers, the department received the list, and we were classified as 'others', yet we are the people fighting this pandemic. We used a lot of fare, we used a lot of our airtime, and no other cadre used what we used." (Respondent5)

"I don't think we have healed completely, Because there was no appreciation, no one was there to say 'yes, I know this group did this'. At the end of the day, it was like that was your work." (Respondent 2)

Community distrust and enforcement-driven compliance

According to CHSCs, many community members believed COVID-19 was politicized and exploited for the benefit of a few. Inconsistent role-modelling, such as political leaders flouting restrictions on public gatherings, further eroded trust and fuelled community distrust of public health guidance.
"There was no role-modelling. Because they [politicians] were talking about social distance but yet we would find them going to political meetings with crowds and they were not wearing masks. So, the community were wondering if the leaders were not wearing masks, adhering to the COVID-19, so why should we?" (Respondent2)

"and one of the greatest reasons was the mistrust of anything to do with the government, and especially handling COVID. And especially when the COVID billionaire thing was aired. It has become quite a task to let the communities know that they still have a responsibility in responding as guided by the ministries." (Respondent1)
As a result, the community members' initial adherence to COVID-19 mitigation guidelines ceased. This lack of confidence resulted in a failure to follow the COVID-19 criteria, where adherence was primarily driven by the desire to avoid penalties rather than genuine health concerns.

"…our policemen and enforcement units took the control measures as a cash cow for them. Because people would wear masks just so that they were not arrested" (Respondent 5)

Fear-driven disruption of health services and reduced health-seeking behaviour

The CHSCs relayed that access to health services was impeded by apprehension, the perception that health facilities were COVID-19 epicentres, and a general unwillingness to seek medical attention due to the possibility of being diagnosed with COVID-19.

"There was a stigma at the community level… hospitals branded as a hotspot for COVID… people kept away unless 'very sick' by their own judgement." (Respondent 1)
"Diabetics and those with NCDs kept off facilities… they believed every case would be diagnosed as COVID." (Respondent 2)

"There were so many home deliveries… mothers could not cross the lockdown… majority ended up delivering in their homesteads, having complications." (Respondent 4)

The community members held a widespread belief that health facilities were COVID-19 hotspots. This fear of COVID-19 was further enhanced by the lockdown measures enforced by the government, using roadblocks. This prevented community members from reaching their facilities for services and treatment, and also hampered the referral functions of CHVs.

"..there was also the notion from the community that every case that presented itself to the hospital would be diagnosed as COVID. So, they would keep off regardless of which

symptoms you have, because even diabetics and those with NCDs, they would keep off the facility…" (Respondent2)
"They didn't want anything to do with health-seeking issues at the facility level…" (Respondent 1)

"One of the things we noted was the health-seeking behaviour, where cancer, HIV patients and people managing chronic conditions were not able to access the hospitals of choice." (Respondent 6)

Discussion

Our study provides practice-level insight into the lived experiences of CHSCs during the COVID-19 pandemic in Kiambu County, Kenya. By capturing perspectives from all twelve coordinators county-wide, the findings illuminate both operational challenges and psychosocial burdens at the interface of policy and community action. While specific to Kiambu, these insights can inform county preparedness strategies elsewhere with similar community health structures. Participants described a mixed legacy: increased familiarity with community-based healthcare services, but also enduring fatigue, erosion of trust, and feelings of neglect that will require deliberate rebuilding.

Stigma toward health workers, reported in Nigeria [14], was mirrored here. In the aforementioned study, the experience of stigma was reported by health care workers (HCWs) during the COVID-19 pandemic [14]. The 'justifications' for stigmatizing the HCWs ranged from fear of becoming infected, lack of understanding of COVID-19, and avoiding those working at the isolation centre, similar to the present study. Fear of infection and misinformation led to community avoidance; even relatives distanced themselves from the CHSCs in our study. Beyond stigma, emotional distress stemmed from handling COVID-related deaths and witnessing mortality without formal psychosocial support. Similar mental health impacts have been documented among Kenyan hospital staff [15] and community health workers across multiple countries [16]. These findings highlight the importance of embedding psychosocial support, such as debriefing sessions, peer support networks, and accessible counselling, into pandemic response plans [17,18].

The CHSCs reported a lack of essential resources to carry out their duties. Similar scenarios were reported in a study conducted on CHVs in Benin during the Lassa virus outbreak [19] and in rural Sierra Leone during the Ebola outbreak [20]. Weak supply chains and underfunded transport stipends hindered coverage and undermined morale, which have also been described in other studies [15,17,20,21]. County-level buffer stocks for essential commodities, as well as flexible transport stipends, pooled vehicles, could improve responsiveness. Such measures require predictable funding streams; an ongoing concern given recent reductions in Kenya's health sector budget [22].

Feelings of abandonment were compounded by perceived inequities in risk allowances. Similar emotional distress has been previously reported among doctors and nurses working at one government and two private hospitals in Kenya during the first and second wave of COVID-19 [15]. It has also been shown in CHVs in a study by Salve *et al.* based on evidence from India, Bangladesh, Pakistan, Sierra Leone, Kenya and Ethiopia [16]. While hazard pay structures vary, overlooking coordinators who supervise and mobilize frontline workers risks demoralizing a cadre critical to community-level primary health care. Performance-based recognition and transparent incentive criteria may better sustain morale while avoiding favouritism.

The information on community perspectives regarding the COVID-19 response, as reported by CHSCs, detailed government distrust due to a lack of role-modelled leadership. This is rooted in a contradiction of actions and hypocrisy on the side of politicians and public figures. There were similar findings in a study conducted in the United Kingdom from anonymous social media platforms, noting that politicians were dishonest and looked out for their own selfish interests [23]. In our study, as enforcement measures were perceived as punitive or revenue-driven, adherence became more about avoiding arrest than protecting health.

Fear of health facilities as COVID hotspots, compounded by movement restrictions, discouraged clinic visits and disrupted chronic disease care, paralleling findings from the United States [24], and similar LMIC settings [16]. Future risk communication should pair clear messaging with visible role-modelling by leaders and ensure essential services remain accessible even under movement

restrictions. Similar findings were demonstrated in a study by Salve *et al* [16].

The Primary Health Care Act (2023) envisions universal health coverage built on community health services [9]. Yet, as CHSCs noted, repeated appeals for local funding have seen limited success [25], and national budget cuts jeopardise the very "Level One services" on which PHC rests. Practice-level actions (reliable transport and PPE, protected mobility passes for community teams, psychosocial care, and community co-designed risk communication) are immediately actionable steps counties can adopt to strengthen preparedness. Broader structural reforms, including consistent resource allocation and recognition of supervisory cadres, remain necessary but should be framed as areas for further policy dialogue rather than definitive national prescriptions from a single-county study.

A key strength is the census approach: all twelve CHSCs participated, providing comprehensive county-wide perspectives. However, experiences were recalled retrospectively after the pandemic "peak" (i.e., in 2020), introducing potential recall bias. Because participants were senior coordinators, their accounts may not fully capture the nuances experienced by community health workers or households themselves. Additionally, all analysts were county health staff, raising positionality considerations; with reflexive journaling, peer debriefing, and anonymization mitigating but not eliminating this risk.

Conclusion

CHSCs in Kiambu County sustained critical community response functions under conditions of scarce resources, stigma, and psychological distress. Their accounts underscore that community health preparedness depends not only on commodities and protocols but also on workforce well-being and public trust. Strengthening preparedness will require sustained investment in county-level logistics, equitable resource allocation, and psychosocial care for frontline coordinators.

What is already known about the topic

- Community Health Strategy Coordinators (CHSCs) play a vital role in coordinating primary healthcare services and community health interventions in Kenya.
- During the COVID-19 pandemic, many low-resource health systems, including Kenya's, relied heavily on community-level health actors to manage public health responses.
- Community engagement is a recognised strategy for managing health emergencies, but its implementation and support vary significantly across regions.

What this study adds

- Provides first-hand qualitative insights into the lived experiences of all the 12 CHSCs in Kiambu County during the COVID-19 pandemic.
- Highlights critical systemic gaps, such as inadequate PPEs, transport, and psychosocial support, that hindered CHSCs' ability to effectively respond to the pandemic.
- Reveals the psychological toll on CHSCs, including trauma from duties like body disposal, and community mistrust that undermined public health efforts.
- Emphasises the urgent need for structural investment in community health systems, including equitable resource distribution and mental health support for CHSCs.
- Uniquely contributes to strengthening community-level preparedness and psychosocial resilience by linking lived experiences to actionable reforms that can inform future emergency response planning.

Competing Interest

The authors of this work declare no competing interests.

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Authors´ contributions

MMK: Conceptualization; Methodology; Project administration; Investigation; Data curation; Formal analysis. BM: Supervision; Resources; Project administration. JN: Supervision; Data analysis; Writing – review & editing. PKJ: Data curation; Formal analysis; Writing – original draft; Transcription. BK: Formal analysis; Writing – original draft. NW: Formal analysis. AOO: Supervision; Resources; Writing – review & editing.

Data availability

The data is not available in a public repository, but anonymised data can be provided upon request.

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