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Original Research Article

To what extent do community members participate in planning, implementing health programs within their communities and what are the benefits of their participation in Nigeria?

Nwadiuto Chidinma Ojielo*, Enyinnaya Etiaba, Obinna Onwujekwe

Department of Community Medicine, University of Nigeria Teaching Hospital, Nsukka, Enugu State, Nigeria

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***Correspondence:**
Dr. Nwadiuto Chidinma Ojielo,
E-mail: ojielonwadiuto@gmail.com

ABSTRACT

Background: Community participation in health programs helps drive collaborations between the formal health structures and informal health system actors in promoting health at the community level. This paper provides new information on the extent of community participation in the planning and implementation of community-based health programs in Nigeria as a trajectory for strengthening the health system.
Methods: This was a qualitative study. Data was collected from three located in different geographic zones of Nigeria. Two local governments (rural and urban) with evidence of health programs were purposively selected in each state. Data were collected through in-depth interviews and focus group discussions. The data was transcribed, coded manually and analysed thematically.
Results: Several health programs were identified in the community. It was found that while community leaders are hardly involved in conceptualizing and planning health programs, however, they participate in program implementation by mobilizing community resources and encouraging members to take advantage of available health activities. Our findings also showed increased benefits of the involvement of the informal health workers in the health system.
Conclusions: Community participation and involvement in health as part of community health system (CHS) activities has led to better and well-improved services, increased willingness to access immunization services. Communities are readily available to contribute to health activities, but they should be involved in the initiation and planning of health activities for ownership and full participation. This would improve health outcomes and contribute to strengthening the community health system.

Keywords: Community, Health, Nigeria, Participation, Program

INTRODUCTION

Since the Alma Ata declaration of 1978, community participation (CP) has been recognized as one of the core strategies for achieving the goals of health for all (HFA). The benefits of CP are numerous to the communities, the health systems and the governments.[1] In primary health care, community participation stands as a fundamental principle known to yield various advantages such as enhanced health results, fairness, increased access to services, relevance, acceptance, quality improvement, and responsiveness.[1] The involvement and accountability of the community play a pivotal role in reaping these benefits. Engaging actively in community-driven initiatives, both adults and youths contribute to village committees aimed at service enhancement. Additionally, communal engagement through activities like viewing plays or videos and attending presentations regarding

local programs serves as a means for collective learning and awareness-building.[1] Community groups play an important role in ensuring health security for the people. Hence, the involvement of the end users of health services in health-producing-activities for persons usually bound by geography or a specific characteristic is very important in ensuring a holistically well-functioning health system.

Community participation is an important principle in the delivery of primary health care and it guarantees the positive changes desired in the uptake and sustainability of primary health care programs.[2] Community involvement in health is a deliberate strategy which systematically promotes community participation and supports and strengthens the health system in order to provide better health care for the majority of people.[1] Community participation came to the fore in both the 1978 Alma Ata declaration and the 2018 Astana declaration, which framed the community as central to the planning, organising, operation and control of primary health care.[3]

Community participation is a key health system building block. Hence, the WHO building block was expanded to inculcate community involvement and participation in health.[4] Community involvement and participation in health is described as a partnership between government and local communities in the three key areas of planning, implementation and utilisation of health programs.[5]

Recently, the concept of a community health system (CHS) which holistically identifies formal and informal dynamics at the household and community level is being recognised.[4] The CHS is a new grey and disputed area of research. Different people understand and define CHSs in different way.[6] Hence, health programs are implemented at the community level, and many with community participation and involvement serve as ways to bring critical services to the hardest-to-reach children and vulnerable populations who need care.[7]

In Italy, it has been criticised that in practice, community participation frequently ends up as mere empty words.[8] In Ireland, despite the fact that the participants were capable of articulating the concept of community participation in primary health care (PHC), there was a lack of consensus regarding the specific tasks and responsibilities within or between health service providers and community settings.[9] In a case study on the response to the earthquake in Nepal, it was found that community members, especially female community health volunteers (FCHVs), were at the centre of the response.[10] Another study in Ethiopia, revealed that enhancing the resilience of community-based health systems amid the drought was made possible by robust communities and adaptable community health workforces within health systems that responded effectively to the population's requirements.[11]

In Africa, a study reveals exists insufficient evidence regarding the functionality of health committees across all provinces in South Africa. Available data indicates that these committees often lack effectiveness due to ambiguity surrounding their roles, autonomy, authority, support, and capacity.[12]

In Nigeria, community participation is officially recognised as one of the health systems building blocks where increased attention is required for improved functioning and effectiveness of the health system.[13] The most recent Health Minister for Nigeria (2023) has recognised the community health system as a distinct entity and prioritised the strengthening of primary health care and community healthcare.

Although many health programs are integrated into the primary health care (PHC) system, barriers to access such as high costs, insecurity and long distances to health facilities may prevent households from utilising health facilities.[14] However, it has been shown that effective community participation significantly improves health awareness and uptake of health services in both rural and urban locations.[15,16]

There are some documented examples of community involvement in health and success stories. However, there is a need for a closer look at strategies for the implementation of community participation in various aspects of health, including research and delivery of health services so as to harness and positively channel the strengths of community participation in health.[17,18] Thus, there is a need to explore the extent of their participation in the health system.

The aim of this study was to determine the extent to which communities participate in the planning and implementation of their own health. Also, to learn the involvement of the informal health providers and their success stories in their various communities. The objectives were to identify health programs in the community, the roles of the informal providers in the community, the community structures that facilitate and constrain the participation of the community members and the benefits of their involvement in health.

Hence, this paper provides new information on the extent of community participation in the planning and implementation of community-based health programs in Nigeria as a trajectory for strengthening the health system. It also explores the enabling community structures and nature of action and the involvement of informal health system actors in community participation and involvement in health.

This will help in providing decision-makers the evidence that they require to strengthen community participation as an intrinsic part of health system building blocks and as an integral part of the community health system.

METHODS

Study design

This was a qualitative cross-sectional design with in-depth interviews (IDI), focused group discussion (FGD) and key informant interview (KII). The duration of the study was 1 month.

Study area

This study took place in Kano, Akwa Ibom and Anambra States situated in the Northwest, South and South-East of Nigeria respectively. The three states were purposively selected because they have strong community involvement in community health system projects and to represent different geographic parts of the country for better understanding of the subject matter that could differ in different parts of Nigeria. Two local government areas (LGAs) were chosen in each state to represent urban and rural areas.

Data collection

Primary data was collected using qualitative interviews. There was also secondary data collection through desk review- review of relevant documents. Primary data was collected through face-to-face in-depth interviews (IDIs) and focus group discussions (FGDs) with community members and health providers across different levels of the community healthcare system. There were 90 IDIs and 12 FGDs in the three states. Separate pre-tested interview guides were used for both the IDIs and FGDs. Respondents were both formal, and informal health providers. The FGDs were conducted for community groups that included market women and age grades Details of respondent categories and number of interviews are summarized in Table 1.

Table 1: Summary of IDI respondents and number of interviews.

Respondent category	Akwa Ibom	Anambra	Kano
Health sector policymakers	3	2	3
Health program managers	2	2	1
Formal healthcare providers	4	3	4
Informal healthcare providers	13	7	11
Intermediary health workers	-	-	3
Private health sector	-	4	-
CSO/NGO	2	4	3
Community or religious leader	7	5	7
(FGD) community groups/ service users (women)	2	2	2
(FGD) community groups /service users (men)	2	2	2
Total (males)	18	18	25
Total (females)	17	13	11
Total per state	35	31	36
Grand total	102		

The IDIs and FGDs explored the level and nature of community participation and involvement in health. Each interview was audio-recorded with the participant's consent. The data collection data were collected within four weeks (October-November 2022).

Data analysis

Interviews were transcribed verbatim. The transcripts were read by researchers and reviewed for content and context. Thematic analysis was guided by the expanded health system building blocks framework.[19] The themes were generated and colour-coded from the transcripts and then compiled in a codebook with extracted quotes. For anonymity, the respondents were assigned codes. Transcripts were then coded and analysed manually based on the previously generated themes. Emerging themes were also captured, and child nodes/sub-themes were created from each parent node/theme.

Ethical considerations

Ethical clearance was obtained from the University of Nigeria Teaching Hospital (UNTH) Research and Ethics Committee with approval number NHREC/05/01/2008B-FWA00002458-1RB00002323. Prior to conducting the interviews, all participants provided written informed consent, with a guarantee extended to them regarding their prerogative to withdraw from the study at any point.

Participant anonymity and confidentiality were maintained by assigning unique identifiers to each participant during data analysis and reporting and storing the recordings in a password-protected file on a computer.

RESULTS

Disease-specific health promotion activities available at the community level

There were NGO-led programs in Kano State including an HIV program (collaboration of government and NGO) offering free HIV treatment. There were other programs like the volunteer community mobiliser (VCM) program in Kano which encourages and mobilizes pregnant women to access facility-based maternal services which was initiated by an NGO in collaboration with UNICEF. For environmental health, community-based activities in Kano state were implemented to improve health including cleaning of drainages, spraying of insecticides and fumigation and general environmental sanitation.

In Anambra, there was this initiative by the government, ASHIA for sharing of Mectizan and polio immunization. There was also community sensitization and mobilization. They create awareness during programs which motivate community members to access these services.

As a respondent reflects, "*Creating awareness in the community is of utmost importance. There are different social platforms from which people can obtain information at the comfort of their homes but having people they know and trust to come to their houses physically to educate/enlighten them about a certain topic/program encourages them to be compliant more than getting information from social media does*." (29_KN_UB_IDI_IHW).

They also provide security for program staff as required.

The stages of their involvement- development, planning, or implementation?

Findings reveal that there were complaints that they were not involved in the conceptualization, planning and development of these ideas.

"*They do not make these decisions with us. They just impose their decisions on us*" (14_AK_RU_IDI_IP).

"*The government people came from Abuja to distribute the nets without asking us if that is what we really need*" (21_AN_UB_IDI_IP).

However, the community members participate in their health by being actors in the community health services either as formal, intermediary and informal community workers. The formal actors were the nurses, CHOs, and midwives. The intermediary workers were community volunteers either recruited by the government or NGOs.

There were many informal health providers in the communities, and they include traditional doctors such as bonesetters, healers, patent medicine vendors (PMVs), traditional birth attendants (TBAs). For informal health workers, in the community-base, there were the informants, village health committee, the Igwes, PG's, town union, religious union, market union.

"*The key actors or players or groups include the ten-man committee set up by the Igwe (traditional head)'s cabinet comprising of the youth, age grades Okpuno Progressive Union (OPU), members of Igwe's cabinet, town unions, WDC, the age grades, the market women association, men's group*" (26 _AN_UB_IDI_IP).

There were formal connections with informal practitioners. They have meetings where both formal and informal sectors come together, and there was also an organization of patent medicine vendors.

In Uyo, Akwa Ibom, "*we have an association made up of executives such as the chairman, vice chairman, and others, and we meet once a month on the first Wednesday of the month…. we talk about our jobs, and our executives lecture us on which drugs we can sell over the counter and which we cannot, as they belong to pharmacies, and we are also told how to treat our customers*" (12_AK_RU_IDI_IP).

There were many referrals from the informal health workers to the formal health workers. There also were some integrations of TBAs into the formal sector in Akwa Ibom and Kano States.

"*Yes, a lot of referrals take place. The informal health workers refer to the formal health workers*" (13_KN_UB_IDI_IP).

From our study, there were no direct referrals from the formal workers to the informal workers, though they believe the TBAs are doing well. So, they meet with them, refresh their skills, and visit them. Because they believe the patients trust them more than they trust them.

Interestingly, in Kano State, informal health workers refer mental cases to the informal workers.

"*Yes, we do bring patients to the hospital but never to traditional doctors/herbalists. We are even involved in educating people about the dangers attached to taking traditional medicines excessively. The only exception where we refer people to traditional medicines is when the sickness has to do with the brain (mental problem)*." (25_KN_UB_IDI_IP).

There was a linkage of the informal and formal sectors in Kano State. They even hold monthly meetings where they discuss health-related problems and also manage patients jointly. The informal health workers even visit the hospital to monitor their patients "*We are going to the hospital to see how the work is going*"; a respondent in Panshekera community, Kano said

"*We do go to the hospital sometimes to contribute with some information about what we know, we are professional in the field, and we do provide emergency help if it is not beyond our control and if the help is beyond our control, we refer them to the hospital..... Yes, there is, because they even use to talk to us in the hospital because some of the native midwives don't even bother to send the mothers that give birth to the hospital for proper care which sometimes results to the loss of the baby, and also the hospital workers use to be happy when we refer our clients to them, that is why we have a linkage between we and the hospital to avoid problems*." (03_KN_RU_IDI_IP).

Also, in an FGD done,

R5: "*Yes, we have linkage and from the ward head up to the district head. We the VCM, normally hold a meeting every month with district heads, to discuss about the health-related problems and if there is need for further assistance the ward head will also report to district head*." (18_KN_RU_FGD_CGW).

In a particular hospital in Kano, they have CHEW and the JCHEW but no nurses. They have little resources to work with. A TBA attested to contributing money to buying equipment to ensure that her patients experience the best care.

Involvement of informal health workers in health programs

The informal health providers were well known in their communities, and their services have evidence of success. For Maternal and child health, in Nasarawa LGA, Kano state, community mobilisers move from household to household creating awareness on the dangers of delivering babies at home, enlightening and educating pregnant women about the importance and benefits attached to attending ante-natal care. In cases where the pregnant women could not make it in time to the hospital during labour and deliver at home, they give immediate help to both mother and baby before transporting them to the hospital for further examination. Also, they are mobilisers in the ongoing hepatitis vaccination. In immunization in Kano State, they are involved in Community mobilization and awareness creation, free medical outreach, treatment of ailment and provision of free drugs. In Kano State, the PMVs were involved in the tuberculosis anti-process control program.

In Aka-Offot, Uyo, Akwa-Ibom, they are involved in immunization and distribution of malaria medication. The traditional birth attendants (TBAs) were also actively involved in the education of pregnant women as well as maternal and childcare. The TBAs were also actively participating in the promotion of health programs in Akwa Ibom. In Aka-Offot, Uyo, Akwa-Ibom, they provide health education and measurement of blood pressure. They also act as community informants on disease surveillance.

In terms of training, in Kano "*based on qualification, our leader selectively brings local midwives from the society and then the selected ones undergo training on how to conduct deliveries*" (25_KN_UB_IDI_IP). Also, in Pankeshera Community, they undergo training and retraining for TBAs leading to reduced maternal and infant mortality.

They were well trained either by the government or by the NGOs. However, some inherited the skill from their parents. With regards to training of the intermediary health workers, Anambra State was found to be the only state that reported training the workers before they go into the field.

Aside from their apprenticeship position, they also get additional health education and how to handle patients better. The state sometimes improves their capacity through trainings. They are trained to provide basic healthcare information and health management to community members. Informal providers like chemists and bonesetters can be recruited and trained by the PCN.

The main mode of recruitment was through volunteering as observed in Kano and Akwa Ibom States while in Anambra, they were already recruited by the government in consultation with the communities.

Their engagement pattern centred on offering financial assistance to the poor patients, door-to-door sensitization, community project supervision and offering of medical products for free. The pattern of engagement for the workforce with the communities was facilitated through the help/collaboration of community representatives such as TR, president general, youth leaders, market women leaders CHEWs, traditional leaders, faith-based organizations as observed in Kano and Anambra.

There were mostly partnerships and collaborations between the NGOs and the community. "*They are national Program's. Ministry of health, Federal Ministry Health through State Ministry of Health (they're in collaboration) WHO, UNICEF, sometimes, all these agencies, like AFENET and CARTER center. Like the one we give for Mectizan for Neglected Tropical Diseases (NTDs), CARTER center sponsored it*". Some were between the government and the community.

Community structures that facilitated and constrained participation

Enabling community structures for community participation includes groups like the market women group, age grade groups, and religious groups amongst others. Approaches to community organization in Anambra state include Organization of men meeting,

August meeting by women, Umu-Ada meeting, age grade, community engagement and sensitization.

In Akwa-Ibom, the committee project management committee is an enabling community structure. In another community in Akwa-Ibom:

"*There are many groups like Age grades, market unions, the informants, religious groups, women organization, village health workers, youth group, men group and Town unions. These organizations can affect the progress of any health activity in the community*." (26_AN_UB_IDI_PM).

In Anambra State, "*The OIC, and some of the nurses and I also recognized some villagers in their team".*

R 5: *The community members in the team were just there to organize us, while the nurses administered the drugs*.

R 6: *We have women group, OPU. (Okpuno Progressive Union) and the men's group*.

R 1: *Yes, the age grade, out Umuada and, eh for now, I don't remember oh* (14_AN_UB_FGD_CGW).

Factors that constrain service delivery include male dominance in Kano State

"*The main problem is noncompliance from the men in the community, in many cases the women give their full support to us but their husbands prevent them from attending ante-natal or accepting immunizations for their babies*" (25_KN_UB_IDI_IP).

Benefits of community-based health programs on community health

There was an overall output/outcome of the involvement of the communities in the health system includes increased access to healthcare like good roads, affordability of health, increased health awareness and utilization of health services, and decrease in morbidity and mortality.

"*The rate at which children died those days has reduced drastically because of the health awareness*." (15_AN_UB_IDI_CL_WDC).

"*The members of the community have to trek a very long distance before they could even get a Panadol, but now, the health facility is at their door post. Again, before now, sensitization on health issues was very low, but after the intervention the community's awareness on health-related issues was boosted*." (23_AN_UB_IDI_IP).

The insurance scheme in Anambra state has improved financial access to health services. Maternal health services (ANC, facility delivery, family planning) greatly improved, as a result of some of the community health activities in both Kano and Akwa-Ibom States. It is also believed that the involvement of people in health activities has led to the development of many voluntary groups thus creating more awareness in society. This has also led to reduced irregular use of traditional medicines.

Also, there was better education like the provision of computers in school, and an increase in the uptake of immunization.

"*Thus, creating more awareness in the society. One interview said there is no benefit attached. Others said there are Increase in health thus increase in income, increase in awareness…. increase in sensitization… increase in awareness… more access to health… improvement in health... decrease in death... full health package…. water, borehole. This has also led to reduced death rate and irregular use of traditional medicines*." (25_KN_UB_IDI_IP).

The initiatives succeeded in improving the quality and quantity of manpower in the communities. Moreover, most initiatives that are community driven receive greater acceptance from the people as noted in this quote:

"*My opinion is that if the community participated fully in rendering the healthcare services, it will bring more assets to the community living in that particular areas because they are seeing their members participating in their own health program. It will make them to be achievable. You see most of the people in the community, they want to see somebody that is within them, to health educate them, direct them to come to the facility, to health-related services. So, I think that it will improve the health care, in Kano state as well as in Nigeria in general*" (08_KN_UB_IDI_IP).

Some other benefits accruing from the initiatives are high level of awareness among community members about community needs especially on health-related issues, increased attending to the needs of the communities by government, change in superstitiously held beliefs by the community members, increased willingness to engage in family planning, decrease in the number of malnourished children.

DISCUSSION

Findings from this study revealed that community participation and involvement in health as part of community health system (CHS) activities has led to better and well improved services, corrected health misconceptions, increased willingness to access immunization services and patronised government facilities more instead of quacks. However, a few of the findings from this study are similar to a systematic review that assessed Community participation in health systems research and argued that despite positive examples,

community participation in health systems interventions was variable, with few being truly community-directed.[20]

This study reveals the fact that the community members or stakeholders are not involved in the planning of the health programs, rather they are expected to accept whatever is thrown at them. This is not productive because community participation should start from the conceptualization and planning in order to involve and empower individuals and communities to assume greater responsibility for their own health. This is the most important principle of primary health care as defined at Alma Ata. It will also lead to other principles like the use of appropriate technology and self-reliance.

Community participation and involvement also helped community members become more aware of health-related issues and their rights, put pressure on the government to implement projects in the communities, helped in the restoration of hope for the traumatized and stigmatized members of the communities, provided mini-job opportunities to the community members who are paid stipends, procurement of free nets, free blood transfusions, ensured the availability of safer and better drugs, improve and sustain good health among the community members and enabled more persons in the communities to come out and seek treatment. This was in line with findings from a systematic review study done in Singapore on community participation in health services development, implementation and evaluation.[21]

Most of the health interventions or programs we found in the communities were either self-organizing or top bottom. By self-organizing, the community people came together to create and carry out initiatives that will benefit them, such as sanitation, improving health infrastructure, and doing minor repairs of items in the facilities. The health workers tried to link up with informal providers in areas of training and strengthening referrals. On the other hand, top-bottom organisations meant that governments cascaded health interventions and programs to the communities without necessarily demanding their input or feedback. In communities where the top-bottom approach held sway, the community members hoped for more involvement in future.

The findings show that the acceptability of formal health services in the communities will improve if community members consider the behaviours of health workers as empathetic enough, which is a core reason they could prefer soliciting healthcare from informal providers. Others are improved infrastructure, especially power supply and to increase the quantity and quality of staff at the health facilities, so that they could access quality health services round-the-clock.

A common trend found in communities is the sustenance of the craft of informal providers. For most, especially the bone setters, herbalists, and other traditional practitioners, the craft resides within families, and usually not transferred to those outside the families. The TBAs had an apprenticeship system, and so the PMVs. Usually, the TBAs learn how to undertake deliveries of children from more experienced TBAs or from retired nurses and community health extension workers that are resident in the communities. Doctors were said to be present at the level of primary healthcare in the communities, unlike other study sites where there is reliance on doctors provided by ongoing programs. That means, if the programs end, the doctors will leave.

Partnerships existed in several forms, but all geared toward improving the delivery of formal health services in communities. Government, organisations, and providers partner with community structures to improve reception and delivery of health services in the communities. It was widely believed that if the community leadership structure does not buy into health programs, there is the likelihood of failure. So, organisations have been deliberate in setting up community structures such as the co-groups and the voluntary community mobilisers (VCM) in northern-Nigeria to bring about the necessary community presence needed for the penetration of health programs and interventions. Providers in health facilities could play supervisory and coordination roles over community representatives of the health programs. As part of the partnerships, community-based organisations (CBOs) such as the youth organization, were seen playing assistive roles to health facilities, especially in the areas of footing the bills of indigent patients and in sanitation.

In a study conducted recommended that when planning CHW roles and tasks, planners, program implementers, and policy-makers should draw from global guidance and research evidence, however, it is crucial for them to actively connect with the experiences, requirements, and issues pertinent to local communities and healthcare professionals. By integrating insights from both these sources, they can significantly enhance their likelihood of crafting programs that effectively fulfil their objectives while maintaining acceptability among those directly impacted by these initiatives, feasible to implement, and sustainable over time.[22] This is in agreement with a study that recognises the involvement of community stakeholders in health policy implementation will help in mitigating many challenges in the health system.[23]

Understanding the socio-economic and cultural settings of a community fosters the knowledge of what works in the community and provide good leverage of successful implementation of programs. This is important given the argument of Adeneye et al that socio-cultural practices are important in shaping the decision to register in a community-based health insurance scheme (CBHIS).[24]

Existing structures in the communities that aided the penetration of community health programs include faith-based organizations (FBOs), ward development commission (WDC), health facility committees (HFCs),

broader community leadership, and the informal providers. We found cases of health programs targeting the numbers that turn up for religious gatherings, as well as health programs announced in churches and mosques. The authority of the religious leaders was seen to be respected, as their pronouncements could either mean the success or failure of health programs.

A factor that constrains service delivery is male dominance in the communities. The term male dominance emerged during the twentieth century as a conceptual term used to describe the unequal power dynamics between men collectively and women collectively.[25] Women cannot make decisions of their own or participate without seeking their husbands' permission and approval. This is in alignment with a study which reveals that dominance perceptions play an important role in social interactions.[25]

Informal providers also helped with organising their clientele base, preparing them to be receptive and accept formal health interventions. This is in agreement it is believed that involvement of the existing community structures identified in this study in the implementation of health services particularly in the planning process is a practical step in the blueprint for the implementation of CBHIS in the country.[24] This is similar to findings by Sacks et al which showed that to foster better-designed connections between health system policies, structures, planned enhancements, and local communities, it's crucial to prioritise interactions that take into account local community insights, strengths, cultural and social resources, while also addressing limitations and opportunities to enhance capacity for improved health outcomes.[19]

The success and continuity of laudable programs that have been significantly effective hang on proper human resources for health planning.[26] The outputs recorded were reduced malaria mortality rate, increased use of health care facilities, increased disease awareness and community health needs. Major benefits of health activities are better handling of patients as a result of health education and there are happier communities. Improved CHS results in patients seeking treatment again from the same facilities. There appears to be an increased desire to seek healthcare services in the formal health system.

Utilisation of different services at community level led to an improved demand for healthcare services, especially maternal and child health services like immunisation, antenatal care and child delivery. There were remarks that the initiatives reduce the incidence of polio and other childhood diseases like malaria. This is in agreement with a study that found out that strengthening of ward development committees in the communities lead to improved health outcome.[27]

Specifically, the introduction of the community health activities or programs have helped to reduce maternal and child mortality rate, the distribution of the HIV drugs have decreased the number of people dying of HIV/AIDS in Kano state and the provision of the freezer and building for the antenatal and immunization have facilitated service delivery at the community health level.

In Anambra state, the introduction of the community health activities or programs have helped to reduced mortality rates and have helped to increase people's awareness of health-related activities. The health programs have also helped in the prevention of diseases across the various communities studied. Regarding Kano state, the introduction and distribution of the SMC drugs have drastically reduced the high mortality rate of children below 5 years as a result of malaria. Also, the formal health engagement with the TBAs has reduced the number of deaths maternal and child mortality rate in the various communities studied. Furthermore, the nutrition program in Akwa Ibom state resulted to the distribution of vitamin A and deworming of the children. The family planning program too was extremely beneficial as it helped the women control their birth rate. They also make purchasing health affordable to people in the community through community health insurances which is in agreement with a study that shows community-based health insurance scheme is very helpful.[24]

The limitation of this study was communication and language barrier and this challenge was overcome by getting a local to ask the questions and interpret accordingly but not in a matter of losing the content.

CONCLUSION

Informal providers bring health services closer to the communities, even though quality is the concern. Cascading health services down to the communities by encouraging community participation through community representatives improved healthcare utilisation with effects on reduction in morbidity and mortality in Kano. Informal providers help the indigents with credit facilities and could even provide their services for free to such persons. The informal providers, like the bone setters, provided evidence of having remedies to illnesses that proved difficult to handle by orthodox medicine. However, safety and quality of health practices are the concerns for informal providers. There is an overall benefit of the involvement of the communities in the health system includes increased access to healthcare like good roads, affordability of health, increased health awareness and utilisation of health services, and decrease in morbidity and mortality. Enabling community structures for community participation include organised community groups while a constraining factor is male dominance. There is a need for all hands to be on deck to ensure that health is promoted in communities. Co-creation, and incorporation of community health projects into the communities' annual calendar is recommended.

Also, improving the functionality of formal health facilities will lead to improved usage of formal health services, as well as provide a credible referral destination for the informal providers.

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