Facilitating community participation in family planning and contraceptives service provision and uptake: community and health provider perspectives.

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Research

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Abstract

Background: Although community participation has been identified as important for improved and sustained health outcomes in primary healthcare services provision, challenges still remain on how to design and successfully implement it in large scale public health programmes, including family planning and contraceptive (FP/C) service provision. Zambian participants in a multi-country project (the UPTAKE project) provided input in the development of an intervention involving community and health provider participation in FP/C services provision and uptake. This study reports on some of the thematic areas identified by the study participants as critical to facilitating community participation in this project. Methods: This was an exploratory qualitative research study, conducted in Central Province, Kabwe district, in 2017. Twelve focus group discussions were conducted with community members (n=114) and two with healthcare providers (n=19). Ten in-depth interviews were held with key community and health sector stakeholders. Data were analyzed using thematic analysis approach. Results: Four thematic categories were identified from the data as critical to facilitating community participation in FP/C services. Firstly, accountability in recruitment of community representatives and incorporation of community feedback in FP/C services programming. Secondly, engagement and learning best approaches to involve both local and NGO structures in FP/C services provision. Thirdly, building trust through credible community-based distributors and dissemination of appropriate FP/C services information. Fourthly, promoting facilitative strategies that look to address some structural failures such as defeminisation of FP/C services and motivation of community members. Conclusions: Understanding and considering community members' and healthcare providers' views regarding contextualized and locally relevant participatory approaches, facilitators to and challenges to participation, can greatly aid the design, implementation and success of community participation public health programmes. Key words: Community, participation, family planning, contraceptives, programs, accountability, trust, strategies, motivation

Background

Since the Alma Ata Declaration, community participation has been recognised as the foundation strategy for primary healthcare services [1]. It provides a platform for local communities to participate in both activities and decisions that shape their health. Some of its benefits such as community empowerment are not only critical for enhanced acceptability and uptake of healthcare interventions, but also, addressing health inequalities [2]. However, incorporating community participation into health service delivery programs remains a challenge. Some of these challenges are due to the complexity of the participation process, who participates, and inherent power relations in various contexts [3]. Socio-cultural factors that directly influence individual tendencies including lack of awareness, discouraging perceptions about participation outcomes, and lack of trust in the participatory process, are equally challenges to achieving community participation[4]. These conceptual and practical issues have implications for implementing and sustaining community participation.

Global health initiatives particularly in family planning and contraceptive (FP/C) programs recommend community participation as the key strategy for improved provision of services. Community participation has been widely adopted as the central strategy across various FP/C policy documents. The FP 2020 identifies community participation as a principle strategy in expanding access to FP information, services, and supplies to an additional 120 million women and girls in the world's poorest countries by 2020[5]. It underscores the need to move beyond holding governments accountable, towards a focus on community participation in shaping and monitoring coverage, quality and equity of reproductive health services [6]. Further, the World Health Organisation (WHO) strategy on ensuring human rights in the provision of FP/C and services [7], as well as the Global Strategy for Women and Adolescent health [8], equally emphasize the role of community participation in increasing met needs and improving utilization of services.

Though community participation is widely advocated at policy level, designing and successfully implementing participatory FP/C programmes remains a challenge in most settings [9]. A recent scoping review found that community participation continues to be inadequately addressed in large-scale FP/C programmes [10]. Community and healthcare providers' unequal power relationships tend to be a barrier to successful participation in family planning and contraceptive services i.e., unaligned priorities and the inability of community members to communicate their needs and health professionals not being receptive. Even with some of these complexities, ensuring that we find the best possible way to facilitate the involvement of local communities is critical for attaining the broader public health goals.

This study was part of the formative phase of a multi-country project (the UPTAKE project) conducted in Zambia, Kenya and South Africa, which sought to increase met needs for FP/C, through development and implementation of a participatory intervention involving community and healthcare providers (HCPs) in FP/C service provision. In this paper, we explore Zambian study participants' perceptions of community participation and identify factors that can facilitate its application in FP/C service provision.

Methods

Study setting

The study was conducted in Kabwe district, the provincial capital of the Central Province of Zambia, which has a population of 217,843 people of which 58,381 (26.8%) are women in the reproductive age group of 15–49 years [11]. The district was chosen on the basis of its high unmet need for FP/C services, second only to Luapula Province in Zambia. There is a total of 38 health facilities, ranging from the general hospital, clinics and primary health centres, in the district. All these facilities are overseen by the district health management team. Katondwe health facility was chosen as the study site because it has a large catchment area catering for both rural and urban communities (peri-urban). This facility served as a recruitment point for all the study participants.

Study Design

Formative, exploratory qualitative research was conducted in 2017to inform the development of an intervention package to engage community members and HCPs in FP/C services provision and use. This component of the project explored community participation activities and practices in the study setting. Specifically, this paper seeks to report on the underlying processes and strategies that facilitate community participation according to health providers and community members' views. Factors deemed critical by study participants, for a successful participatory program in FP/C services provision, are documented.

Data Collection

Fourteen focus group discussions (FGDs) were undertaken, each lasting between 60 to 90 minutes. Of these, 12 consisted of community members (FP/C users and non-users), and two were conducted with HCPs stratified as managerial and frontline providers (Table 1). Ten in-depth interviews (IDIs), lasting between 30–60 minutes were conducted with various key stakeholders– community leaders and providers of FP/C services (Table 2). Semi-structured questions using an interview guide were administered to the study participants. Some questions in the guide explored study participants' views of what constitutes community participation, who should participate, strategies and challenges of the community working with health providers with regards to FP/C services provision. Interviews and FGDs were audio recorded in local language, Bemba, with participant permission, and transcribed and translated verbatim into English. The data collection team consisted of experienced data collectors with a good understanding of community participation dynamics.

Study Participants And Recruitment

Male and female community members within the reproductive age range (15–49 years) were purposively sampled for the FGDs, and categorised according to age, rural vs urban, marital status and parity (Table 1). The age categories (n = 9) consisted of: adolescents (15–19 years), young adults (20–34 years) and adults (35–49 years). Female groups were further categorised according to location (n = 6) – either rural or urban, marital status (n = 2) – either married or unmarried, and according to parity (n = 1) – with and without children. Though purposive, the recruitment process of community members ensured a participatory approach by engaging a local district coordinator who was recommended by the District Health Office (DHO). The coordinator worked with the nursing sister-in-charge at the study site (selected health facility), together with some community health representative groupings, in recruiting participants for FGDs.

Similarly, HCPs were purposively sampled to ensure representation of FP/C services from multiple healthcare facilities in the district. Recruitment of key informants for IDIs was also purposive to facilitate representation of key groups and key community persons with influence in the health sector (Table 2).

This sampling technique was based on knowledge of FP/C services experts, as well as key community persons who were influential in the health sector such as political, traditional and religious leadership, sexual and reproductive health (SRH) non-governmental organisation representative, district and provincial medical officer, and a teacher from the education sector.

Table 1
FGD participants

Focus group discussions (categories)	Age in years	Participants
Community members		
Females, urban, adolescents	15–19	10
Females, rural, adolescents	15–19	09
Females, urban young adults	20–34	08
Females, rural young adults	20–34	10
Females, urban adults	35–49	08
Females, rural adults	35–49	09
Females, unmarried young adults	20–34	10
Females, married young adults	20–34	10
Females, no-children	18–49	10
Males, adolescents	15–19	10
Males, young adults	20–34	10
Males, adults	35–49	10
Healthcare providers		
Healthcare providers-managerial	-	10
Healthcare providers-frontline	-	09
Total participants		133

Table 2
IDI participants

Participants (categories)	Interviews
Political leadership	1
NHC	1
NGO-SRH	1
Traditional leadership	1
District health office	1
Provincial medical office	2
Teacher	1
Religious leadership	2
Total	10

Data analysis

Thematic data analysis was adopted for the study[12]. This is a method that allows us to capture relationships and dynamics in processes and strategies that shape community participation in family planning and contraceptive services. Data analysis process started with reflections on the information gathered through field notes, memos and observations during conduction of FGD and IDIs. Once the transcripts were transcribed, structural and analytical coding was conducted to narrow down some of the emergent themes in the data (Table 3). A cross country systematic approach involving identifying, checking and iterations of codes across countries to assess reliability and compatibility was undertaken [13]. A qualitative data analysis software program, NVivo 10 (QSR International) was used to organise and manage the data

Ethical Considerations

This study oobtained ethical approval from the University of Zambia Biomedical Research Ethics Committee (UNZABREC). All participants (> 18 years) provided written, informed consent to participate in the study. Participants under the age of 18 years provided written assent, and their parents/guardians provided written consent for their participation. In the event that participants were not literate, a witness was required to be present during the consenting process and sign consent on their behalf. The participants gave separate consent to being audio recorded.

Results

Though the UPTAKE Project explored perspectives from a varied group of participants, no major differences in perspectives were reported amongst them with regards to community participation in FP/Cs services. Data are presented based on community members', healthcare providers' and key stakeholders' perspectives. Through the process of analysing the data, four core thematic categories emerged from the data as critical to facilitating community participation in FP/Cs services. These include accountability, community engagement and learning approaches, trust building and facilitative strategies.

Table 3
Data code list

Structural themes	Analytical themes
Accountability in FP/C services	• Appropriate community representation • Incorporation of community feedback in programming • Effective suggestion boxes usage
Engagement of community structures	• Involvement of family planning champions • Youth engagement through youth friendly corners • Leveraging established community structures
Trust building	• Appropriate and timely information on FP/C methods • Community and provider regular meetings and information exchange • Credibility in selected community facility representatives
Facilitative strategies	• Defeminization of contraceptive services • Motivation of community members

1. Accountability in FP/C services provision

Accountability was generally thought to be an important component of FP/C services programs. Both the community members and HCPs indicated that to facilitate community participation, FP/C services had to be accountable in various aspects. This thematic category underscores the importance of FP/Cs programs' responsibility to ensure that appropriate people are involved in FP/Cs, they strengthen community FP/Cs services feedback mechanisms, as well as ensuring that participation occurs within the local context of a given community to facilitate participation.

a. Defining participation and who participates in family planning and contraceptive services programmes

According to both community members and HCPs, community participation was defined as the willingness or process of being involved in activities that improved the lives and health of communities. It was a combination of community member efforts in activities and programs of mutual benefit.

Community members thought participatory programs were beneficial as they facilitated knowledge, skills and resource sharing. Additionally, they expressed that meaningful community participation could only be attained if community members were well sensitized about a given programme or activity prior to implementation.

> *"I think community participation this is the willingness of the community to participate in all the activities that are taking place in our centres. Since we are talking about family planning, it means they should involve themselves in sensitizing people especially to those who have knowledge about it. They should take part in sensitizing those people who don't have knowledge about family planning, that's what I think." [Female FGD, Unmarried, UZFG_C008]*

> *"I think I can define it, I can define it… as how an individual or the attitude and maybe the effort in which you put in doing things [for] the community." [Male FGD, Adolescent, UZMG_T007]*

Community members suggested a number of possible participants in FP/C services activities. They recommended that both adults and adolescents should be involved because FP/C is a cross cutting issue. Bringing them together would help foster understanding and create the much-needed community support for adolescent use of SRH services. It would also help deal with the judgement and stigma causing possible discomfort that either of them may experience when accessing FP/C services at health facilities. The adolescents indicated that such participatory programmes could offer an opportunity for them to learn from adult experiences in using FP/C methods and services.

> *"I think it's everyone who should participate. Both adults and young people because this affects all of us." [Female FGD, Urban Adolescent, UZFG_UT002]*

> *"Also, the parents, they have to be involved in the programmes so that they support their children, so that they don't feel shy about it" [Male FGD, Young Adult, UZMG_Y006]*

Both community members and HCPs felt that since men are key decision makers in FP/C methods choices, it is imperative that they participate in FP/C services so that they can better understand the benefits of these services and therefore provide support to their wives/female partners. They indicated that it was important for FP/C programmes to find innovative ways to involve men. It was felt that both married and unmarried, as well as the sexually active and non-active community members should participate in FP/C programmes to get empowered with information for them to make informed reproductive health choices.

> *"Both men and women should play an active part because if part of the community say 'no this is for females alone', then we will not win. But if everybody in the child bearing age plays an active part such that when they are given information, they share with a neighbour, then this information will go to the whole community and everyone will access family planning." [Key stakeholder, Health sector, UZI003]*

b. Enhancing established feedback mechanisms –suggestion boxes

The HCPs reported that regular and consistent use of suggestion boxes in healthcare facilities, by community members, is essential to providing feedback on FP/C services. Suggestion boxes provide a platform to get community member's voices on their experiences with FP/C services– the lapses and how to improve quality. However, there was no clarity on how these suggestion boxes were introduced and what role the community played. HCPs also stated that there was limited information in most communities on how to appropriately use suggestion boxes.

> *"You can get information from the community's responses to the services that are provided through the suggestion box as one of the ways. Through the suggestion box they can even suggest on how best the services can be rebuilt in a health facility where they seeing some lapses. However, community members don't know how to use these facilities well" [Healthcare Provider FGD, Managerial, UZHG_H004]*

Although suggestion boxes were widely available in all facilities, HCPs further indicated that they were not being used by community members. Community members believed that by using suggestion boxes they would be risking their access to healthcare if identified by the HCPs. HCPs suggested that community health workers (CHWs) could be used to educate community members on the importance of these suggestion boxes, and that they should also be located in convenient and private places where clients/potential clients could drop their suggestions without fear of possible discrimination or stigmatization.

> *"Currently, suggestion boxes are not being utilized as they are supposed to be, because community members usually fear to be seen. They think maybe they might be stigmatized once they are seen going near that box to put in whatever suggestion they may have." [Healthcare Provider FGD, Managerial, UZHG_H009]*

2. Engagement of community structures

The second thematic category brought to the fore the importance of engagement in facilitating community participation in FP/C services. Participants identified some of the structures already doing FP/C work within their communities and how they could best be leveraged. Further, participants identified particular categories of people with influence that could play a role in FP/C service provision, including information dissemination and demand creation. For example, they described the critical role of FP/C champions and community groups, churches, and support of youth friendly corners as ways to reach out to adolescents.

a. Working with family planning champions

HCPs suggested that involving influential community persons, like councillors, ward committee chairmen, religious leaders, headmen and chiefs, in community FP/C services sensitisation efforts would facilitate

community participation. Leaders were stated to command huge respect and were viewed as gatekeepers in society. Some leaders had already been selected as FP champions in previous programmes in order to lead community mobilisation efforts. It was reported that champions could use their political, traditional and religious powers to influence others on the importance and benefits of participating in FP/C services programmes.

> *"I think if we can involve the leaders, we bring them on board and teach them the importance [of] family planning, it will help us a lot. You can imagine how many people are staying in [name of area], but there is headman there, there is a leader there, who can influence those men and make them understand the importance of family planning." [Healthcare Provider FGD, Frontline, UZHG_L004]*

b. Support and strengthen youth friendly corners

Whilst most HCPs reported that their facilities had youth friendly corners –spaces where adolescents can access SRH services at health facilities– they also indicated that many were not fully functional. Not many youths were utilising these services due to logistical and local challenges, particularly due to stigma/judgment around adolescent use of FP/C methods/services. It was suggested that youth friendly corners be strengthened to deal with adolescent SRH needs– through providing incentives and enhanced youth participation. Strengthened youth friendly corners can provide a platform for dialogue between HCPs and adolescents, as well as sensitization on FP/C methods and services use, hence facilitating participation.

> *"I think in the past we have somehow overlooked the teenagers, but there is now more emphasis on teenagers. The last time we had a planning meeting, we only had 12 youth friendly corners the whole province and some of them are not fully functional. There is need to increase the number of and improve support to youth friendly corners in all the facilities, if we to improve adolescent use of contraceptives". [Key stakeholder, Health sector, UZI006]*

c. Leveraging local community and sexual reproductive health non-governmental organisation structures

Both HCPs and community members, especially those from rural areas, pointed out that community participation could be achieved by exploring and strengthening existing structures of community healthcare cadres such as traditional birth attendants, neighbourhood health committees, safe motherhood action groups and community-based distributors. These act as a link between the community and healthcare system, providing a wide variety of healthcare services to people who cannot be reached, due to factors such as long distances from facilities. For example, they conduct health education as well as provide actual FP/C methods such as Oral Contraceptive Pills and condoms to communities in hard-to-reach areas, together with information on other methods available at the facilities. The HCPs stated that it was easy to work with the CHWs because they can be motivated with non-financial incentives. They also stated that CHW, if trained, could as well learn to provide contraceptive injections in the community.

"In this community, we have what we call the Safe Motherhood Action Groups, these usually disseminate information within our community, but for Kabwe I think the only people that are used to provide that information are the Community Based Distributors. Those are the ones that disseminate part of the information on family planning and also distribute basic family planning commodities." [IDI, Key stakeholder, Health Sector, UZ1006]

"The community health workers are motivated when they are called for a meeting, and then they are given books, ball pen or maybe a bag with an ID. It is a lot of motivation to them. Others feel like bicycles are more motivation to them so that they are able to reach other families that are far away and provide health education [to] them or maybe even give contraceptives." [Key stakeholder IDI, Health sector, UZI006]

Local non-governmental organisations such as Society for Family Health, Marie Stopes and Zambia Prevention, Care and Treatment Partnership, were reported to be actively providing SRH services in most communities. The HCPs however thought that some NGOs were more focused on reporting improved quantitative indicators of service provision –that is the number of people accessing a given FP/C service, rather than the participatory processes that allow people to be more informed and involved in FP/C services provision. The emphasis on increased numbers of clients was reported to negatively affect the quality of FP/C services according to the HCPs. They suggested that the NGOs and health centres should work in harmony with the community members by providing accurate information as well as FP/C services.

"The biggest challenge we find as healthcare providers is that NGOs demand a lot of numbers [high level of commodity utilisation]. This tends to have repercussions on how we provide these services. Let's say maybe in a day I have been assigned to insert twenty Intra Uterine Contraceptive Devices, I won't have much time to give all the information for each and every other method which we may have, in a rush to reach that set target". [FGD, Frontline HCPUZHG_L003]

3. Trust Building

This thematic category highlights the importance of building trust in FP/C programmes to enhance community participation. One of the key challenges with regards to sustaining community use of contraceptives methods/services was addressing the myths and side effects associated with use of these. Community members thought it was important that HCP provided adequate information explaining method side effects, in order for them to trust and participate in FP/C programmes. They underscored the importance of providing information on what specific methods are suitable for different users, for more awareness and informed participation. Further, the participants narrated that community representatives such community-based FP/C distributors needed to be credible, that people with respected local opinion for them to win the trust of the community members.

a. Promotion of appropriate family planning and contraceptive methods and information

Community members indicated that promotion of specific FP/C methods to suit different users' needs, was cardinal to facilitating participation in FP/C services. If this was implemented, users would not need to try various methods and experience side effects, before choosing an appropriate FP/C method. Further, community members emphasized the importance of providing appropriate information to counter misinformation around FP/C methods in the community. They suggested that information dissemination targeting community groupings such as women's group was cost effective for any successful participatory effort. Some of the grouping referred to included youth groups, women's groups, local supports groups and the churches. They thought capacity building of various groupings in FP/C methods information dissemination would facilitate reaching a large number of people. It was also reported that FP/C promotion activities need to involve various stakeholders, at both community and health system levels, to not only facilitate co-planning, but also building of mutual trust and support for services.

> *"I think maybe they should be people from the church and people from the health sector and again from the community so that when these people [sit] together, they can plan well, if there is a person who has to talk about natural family planning, they should talk within the same fora." [IDI, Key stakeholder, Community leader, UZI009]*

b. Community and healthcare provider meetings/dialogues

Key stakeholders reported that participation in FP/C programmes could be enhanced if HCPs were more willing to engage and work with community members in all aspects of service provision. Community members suggested this could be done via community dialogues, trainings or meetings. They indicated that attending community meetings on FP/C methods/services was motivating in particular to community-based distributors (CBDs), because it allowed them to gain more knowledge. Community dialogues were also highlighted to be an important platform for engagement of HCPs with community members on FP/C services. For example, community members stated that that ongoing dialogue and meetings between the community and HCPs regarding adolescent use of FP would be important to encourage parents to open up towards adolescent use of FP/C services. Further, the dialogues could allow for community members to share their concerns about FP/C services. The community members narrated that with proper training on use and increase knowledge about methods and side effects, CBDs could properly explain FP/C methods to the community member and hence foment trust and awareness.

> *"Continuous dialogue, training and meetings and other interactions between health workers and the community will make people become aware of the benefits of family planning and participate in these programmes. It [is] also a nice platform for people to talk about some of the issues they have with family planning [Male FGD, Urban Male Adolescent UZMG_A003]*

c. Credibility of community representatives

Healthcare providers expressed that CHWs may face rejection if the community members think that they are not knowledgeable enough to talk about FP/C methods and services. In such instances, their credibility would be questioned, hence affecting community members' demand for FP/C services. It was

also suggested that selection of CHWs should be done with support from local leadership and general community membership, otherwise they could face challenges in executing their duties. This locally driven process assures community buy-in and support, and ensures that community members with credible reputation are selected.

> *"Concerns are there sometimes because of their status especially where we don't call the leader to explain to them that these are the people who we will be working with and will be in the community. The leaders will reject them because they have never been chosen by the leaders," [Healthcare Provider FGD, Frontline, UZHG_L002]*

4. Facilitative strategies

This thematic category underlines community experiences with the current set-up of FP/C services programs, and how this affects participation. It highlights critical challenges to participation inherent within health systems structures and the possible role of facilitative strategies. The participants discussed the feminization of family planning, demotivation of community members due to short project life and the valuable role of facilitating male involvement in addressing some of the issues.

a. Defeminisation of family planning and contraceptive services

Key health sector stakeholders narrated that FP/C services were predominantly designed for women, which deliberately excludes men from participating. The terminologies used to refer to particular FP/C services seemed to exclusively imply that only women are to be involved, while this is in the contrary. For example, the terms "Maternal Child Health" or "Prenatal Services" were felt to be discriminatory to men. According to the key stakeholders, making services inclusive would require revisiting the departmental names as well as creating infrastructure that is welcoming to both males and females within the health systems.

> *"When you say parental, even I as a man I will feel welcome at this place. But if you are telling me this is a clinic for mothers and children you have excluded the men. You even go to the extent of creating a Ministry of Gender where you are excluding them [male]." [IDI, Key stakeholder, Health sector, UZI007]*

Outreach activities that encourage parents to talk about contraception with their children were suggested, as critical to supporting adolescent FP/Cs services within communities. Community members suggested that community volunteers, like the NHCs and SMAGs could be further trained in counselling services. Counselling skills and approach technics were said to be vital especially in rural areas, where some male community members were thought to be against the idea of FP/C methods.

> *"Even before we access the Family planning from the clinic, even in our very homes we are coming from, we should try to talk to our children about the benefits of family planning since we know it*

already as parents. I think health providers should encourage this practice in their outreach activities.' [Male FGD, Young Adult, UZFG_UZMG_Y003]

b. Motivation of community members

Community members reported that discontinuation of most funded participatory health programmes was a challenge to participation, whereby community members may be demotivated to participate in new programmes as they have concerns that they may eventually close down. They reported that this often occurs at the end of a project life when there is termination of funding supporting participatory activities within community groups, such as sport, drama and other local groupings. Although clubs/groups were viewed as more organized platforms for sharing and transmission of information among community members, it was described that recently, some of groups like the drama clubs and the football clubs had not been working due to lack of motivation, disinterest, lack of time and support. It was described that the challenge sometimes was that people participated in these groups with the hope of acquiring monetary or material benefits, and that when there was none, they simply left. Key stakeholders suggested that it was important for programs to embed some activities within routine community practice as opposed to having all activities program fund dependent to allow for sustainability as well as continuity.

"What I can say is that all the clubs, community groupings, the drama clubs and even sport, they can work and again they can't work. What makes them work is the motivation. Wherever you go, when there is no motivation, nothing works, and where there is motivation things [go] well." [Male FGD, Urban Young Adult, UZMG_Y001]

Discussion

This study reviews that that facilitating community participation in family planning and contraceptive programs will require a focused approach that pays critical attention to thematic areas of community engagement, accountability, trust building and facilitative strategies. These findings shaped important aspects of the design of the UPTAKE Project, particularly with regards to exploring appropriate mechanisms for community and health provider engagement in contraceptive provision and use. These findings are also applicable to other participatory programs in similar contexts. Whilst this paper focused on community participation, other aspects of the formative research for the UPTAKE project are discussed elsewhere[14, 15].

Of importance to the community members is being able to involve trusted community representatives and appreciation of the influence that the local network of community structures has. Further, FP/C programs should be accountable and ensure such mechanisms are in place not only for feedback but also addressing the quality chasm of service provision. These finding are consistent with various literature of community participation. Atkinson systematic review on the architecture of community participation highlight the role of engagement in facilitating community in communicable disease control

programs[16]. Further, these findings are in alignment with the concept of collaborative governance in community health systems[17, 18].

Whilst community participation is undoubtedly a key component of delivering inclusive and sustainable primary healthcare, challenges regarding how to integrate it into health programmes still remain. One review found that the dominance of the bio-medical paradigm as the main planning tool for participatory programmes, leads to viewing of community participation as an intervention as opposed to a process [19]. Lack of in-depth analysis of the perceptions of community members and the propensity to use frameworks that limit investigation into what works, why and how, further limits the integration process of participatory approaches in health services [19]. Understanding of what constitutes a community, who actually represents genuine community interests, and who should participate in given health programmes are essential activities in designing and implementing successful participatory programmes [19].

Strengths And Limitations

Conducting the study in only one setting in Zambia, the use of a small sample of respondents as well as using only a qualitative approach to collect data, limits the extent to which the study can be generalized. However, even though generalizability was not the intention, the rich description of phenomena (community participation) helped in developing an account that we believe provides a valuable contribution to the knowledge on FP/C services provision and use in low income settings. Also, collection of data from the various categories of both users and non-users, and providers enabled gathering of a wide range of views on key issues affecting community participation in FP/C services programmes at different levels, which allowed for strengthened triangulation of perspectives on key thematic areas among the different participants. Furthermore, the iterative reading and rereading of the collected data allowed for constant comparisons to increase the validity of the emergent themes.

Conclusion

Facilitating community participation in FP/C services programmes will require that implementers comprehend key process that may hinder or facilitate participation. Implementers should plan on how best to make these approaches effective in a given context. Further, they should consider some of the underlying and possible context relevant activities or structures that enhance and consequently maximise participation. Community members are encouraged to have input on the selection of key people to represent community health priorities in family planning programmes. Understanding and considering community member's views regarding contextualised and locally relevant participatory approaches can greatly aid the integration of community participation constructs in the design and implementation of participatory programmes. Future research should therefore focus on understanding the identified approaches and the mechanisms that facilitate participation and produce change through process evaluation.

Declarations

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

Ethics approval and consent to participate

This study received WHO Ethics Review Committee (ERC) and Research Project Review Panel (RP2) approval. In addition, for the Zambian component of the study, ethical approval was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) to conduct the research, and all prerequisite authorisations were obtained from the Ministry of Health.

Consent for publication

Not applicable

Availability of data and material

The data are not publicly available as it contains information that could compromise research participant privacy/consent. However, some anonymised aspects of the datasets may be available upon request and with permission of the Department of Reproductive Health and Research, World Health Organisation. Note that data sharing is subject to WHO data sharing policies and data use agreements with the participating research centres.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

The study was part of the formative phase of a bigger multi-country UPTAKE project, conceived and designed by the WHO (PS, JC), country Principal Investigators (TN) and the qualitative research leads (CM, YK). AS, TN, MM, JMZ, CM, YK: conducted the data collection, analysis and reporting of findings. AS: drafted the manuscript. All authors critically reviewed, revised and edited the draft manuscript. All authors read and approved the final manuscript.

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Abbreviations

CBDs: Community based distributors; CPR: FGDs: Focus group discussions; FP/C: Family planning/contraceptives; HCPs: Healthcare providers; IDIs: In-depth interviews; NGO: Non-governmental organisation; NHC: Neighbourhood health committee; SMAGs: Safe motherhood action groups; SRH: Sexual and reproductive health; STIs: Sexually transmitted infections; TBAs: Traditional birth attendants; WHO: World Health Organisation.

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