

Determinants of Community Health Extension Services by Community Health Practitioners in Ebonyi State

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ABSTRACT

Background: Community Health Extension Services are crucial for enhancing health outcomes and expanding healthcare access in a specified geographical area. However, these services face major obstacles, particularly inadequate infrastructure, which undermines their effectiveness and restricts healthcare access for vulnerable populations. **Objective:** This assess the knowledge, attitude and practices of Community Health Extension Services among Community Health Practitioners in Ebonyi State. **Methods:** The descriptive cross-sectional design is adopted in the study. This study was conducted in Ebonyi State, which is one of the five (5) States located in the South-Eastern region of Nigeria. They are 1263 in number according to the register of the Association of Community Health Practitioners in the State. The sample population of the study consists of 296 Community Health Practitioners that was carefully selected across all the three geographical zones of the States. Sample size was used obtain using the descriptive studies sample size determination formula, by Cochran. Multi-stage sampling method was used in this study to select participants. Data collection was done with a structured questionnaire which was validated by three experts in the field of study and the research supervisor. Data analysis was conducted with IBM SPSS version 25. Ethical clearance was obtained from University of Port Harcourt and School of Public Health before commencement of the study. **Results:** Majority 239(80.7%) of the study respondents are married, more 215(72.6%) of the participants are females, and most 126(42.6%) of them are of aged 26-35 years. Many 140(47.3%) of the respondents have CHEW and all 296(100.0%) of the respondents are Christians. Most 274(92.6%) of the participants have good level of knowledge of Community Health Extension Services, whereas, a minute number 22(7.4%) of the respondents have poor knowledge of Community Health Extension Services. The result showed that most 259(87.5%) of the participants have positive attitude towards Community Health Extension Services, while, a minute number 37(12.5%) of those polled have negative attitude towards Community Health Extension

Services. Most 264(89.2%) of the participants have good practices regarding Community Health Extension Services, while, very few 37(12.5%) of the respondents have poor practices regarding Community Health Extension Services. **Conclusion:** The study concluded that Community Health Practitioners demonstrated a commendable level of knowledge, attitude, and practice toward Community Health Extension Services (CHES). Regular refresher courses, workshops, and in-service training should be organized for Community Health Practitioners to strengthen their technical competencies and keep them updated with emerging Community Health strategies and technologies.

INTRODUCTION

Community health can be understood as the branch of public health that turns its attention toward people, not just as recipients of care, but as active contributors to their own health and that of those around them.¹ It recognises that well-being is shaped within shared spaces, where individual choices and collective realities quietly intersect. In a similar vein, the World Health Organization describes community health as the blend of environmental, social, and economic conditions that support both emotional and physical well-being, allowing individuals to pursue their goals and meet their needs within the context of their specific surroundings.²

At its core, community health applies structured public health principles to reduce early deaths, limit disability, and control disease through coordinated action within communities.³ These approaches span prevention, health promotion, rehabilitation, and treatment, forming a continuum of care that begins before illness and does not end with diagnosis.

Within defined geographical settings, such as local regions in India, community health efforts concentrate on strengthening the well-being of residents as a collective.¹ This involves safeguarding populations, curbing the transmission of infectious diseases, and building readiness for emergencies, including natural disasters. When viewed from a broader perspective, these actions are not isolated tasks but interconnected efforts designed to improve the lived experience and overall quality of life of community members.

Community health practice is understood globally as the delivery of health services aimed at detecting diseases early, identifying environmental and workplace hazards, and preventing or controlling illnesses, particularly within rural populations.⁵ At the heart of this practice lies the community itself, serving as both the focus and the context, a living space where learning, training, and research in community medicine can take root and grow.

Defining a community, however, is not straightforward. It encompasses people connected by shared geography, common interests, or collective goals, even when differences in language, culture, or daily practices exist.³ In this way, the community is not merely a setting; it is an active participant in shaping and sustaining health initiatives, providing both insight and opportunity for meaningful interventions.

Nevertheless, these services are faced with significant challenges, such as a lack of infrastructure, which affects their efficiency and limits access to healthcare for the vulnerable.⁷

In South Africa, community-based health services play a critical role in reducing health disparities and enhancing overall health outcomes. These services, often delivered by frontline health staff, bring care directly into local settings, promoting health education while addressing the social factors that shape well-being.⁸ This approach allows communities to make a difference and ultimately achieve improved health outcomes.⁹ Similarly, inadequate waste disposal and crowded or poorly ventilated housing can fuel the spread of diseases such as malaria, respiratory infections, and even affect mental health. These environmental health issues are particularly pressing in rural areas, where access to medical care is already limited, compounding the vulnerability of communities.¹⁰

The Community Health Extension Program represents a comprehensive approach to health, aiming to improve family well-being through the delivery of preventive, promotive, and basic curative services. Central to this program is the structured application of sixteen health extension packages, designed to address the diverse needs

of families within the community.¹¹ With the healthcare challenges facing Africa, including lack of funding, infrastructure, and human resources, CBHPs have been successfully implemented in different forms, including community-based insurance schemes, health worker programs, and village health teams, with positive outcomes in the reduction of maternal and child mortality, improvement in immunization rates, and the management of chronic conditions.¹²

Since 2009, Ethiopia has implemented the Urban Health Extension Program (UHEP) to bring health services directly into communities. Designed as a cost-effective, pro-poor initiative, the program aims to increase health service utilization while empowering residents to take an active role in managing their own well-being.¹³ Central to this effort are Urban Health Extension Professionals, frontline health staff specially trained to address the unique needs of urban populations. Despite these efforts, a knowledge gap remains regarding how well the community accepts and uses the program.¹⁴ Ethiopia's broader Health Extension Program (HEP) illustrates an innovative approach to primary care, offering essential services to roughly 5,000 people through local health posts embedded within communities.¹⁵ By situating care at the community level, these programs highlight how accessible, locally grounded interventions can transform public health outcomes.

Launched in 2009, the Urban Health Extension Program in Addis Ababa is intended to improve primary healthcare in urban areas by equipping households with health knowledge and skills.¹⁶ Their government launched the Urban Health Extension Program (UHEP) in 2009 with the goal of improving health in urban areas. Trained Urban Health Extension Professionals (UHEPs) empower households to apply health interventions, establishing "model households" that practice at least 75% of the recommended health practices.¹⁷ The Community Health Extension Program (CHEP) is a critical component of the health system in Ethiopia, working to provide equal and accessible healthcare to rural populations.¹⁸

In the Nigerian context, Community Health Extension Services play a pivotal role in enhancing health outcomes and healthcare access. Trained Community Health Extension Workers offer vital services, such as health education and basic care. Nevertheless, these services are hampered by challenges such as underfunding, poor infrastructure, and resistance from the community. Despite the initiatives taken by the government, such as the National Community Health Policy and the Community Health Practitioners Registration Board, major hurdles still exist.¹⁹ The Nigerian approach to Community Health Practice is founded on the principle of enhancing the health and well-being of the community through a comprehensive and participatory approach. It recognizes the significance of community participation in healthcare decision-making and emphasizes the empowerment of individuals and communities to assume control of their health and well-being.⁵

Healthcare utilization is very important in low and middle-income countries such as Nigeria, as it is affected by factors such as socioeconomic status, education, and infrastructure. But the infrastructure in Nigeria, such as roads, electricity, and water, is not adequate, making it difficult for healthcare delivery, especially in rural areas.¹⁹ They also stated that in the rural areas of Nigeria, healthcare-seeking behaviour is greatly affected by socio-cultural factors such as traditional beliefs and practices. Since modern healthcare is not readily accessible, the people in rural areas depend on traditional healers, which may result in poor health outcomes.

Community Health Workers (CHWs) are local healthcare providers with basic training, acting as an important bridge to reach out to the vulnerable population, such as remote areas and marginalized groups, to improve access, equity, and health outcomes.²⁰ They are an important part of health equity and outcomes in underserved areas. Despite their importance, the absence of standardization has been an impediment to their integration into the healthcare system. CHWs are important in providing culturally competent care, support, and advocacy, which addresses health disparities and promotes equity.²¹

Across Africa, health systems face persistent challenges, including a shortage of trained professionals, inadequate infrastructure, and a high burden of disease. In this context, Community Health Workers (CHWs) play a crucial role, delivering primary care, promoting health education, and supporting both the prevention and treatment of illnesses.²² The Centers for Disease Control and Prevention²³ describe CHWs as community-based individuals who strengthen health and well-being by educating, assisting, and supporting their peers. Acting as bridges between healthcare providers and the communities they serve, CHWs help reduce health disparities, promote equity, and lower overall healthcare costs. Their work demonstrates that meaningful health improvements often begin with trusted, local relationships rather than solely relying on formal institutions.²⁴ also found that Community Health Workers (CHWs) play an essential role in enhancing the health of the community, especially in areas where access to healthcare is limited. They help extend the healthcare system to areas that are difficult to reach, thereby filling the gaps in primary healthcare. The lack of health professionals, such as midwives, nurses, and doctors, has increased the burden of diseases in developing countries. The shortage of health professionals is a global problem. Sub-Saharan Africa is a prime example of this problem, as it accounts for only 3% of the world's health workforce but bears 24% of the world's disease burden. South Africa's uneven distribution of medical resources, which dates back to the apartheid era, adds to this problem. Most health professionals migrate to countries with better-paying jobs, thereby further reducing the health workforce. To address this problem, training CHWs has emerged as a major strategy to enhance access to health and improve the world's health outcomes. CHWs play a pivotal role in ensuring a sustainable improvement in the world's health by acting as a bridge between the healthcare system and the community.²⁵

CHPs manage minor diseases, refer patients to specialists, and are the first contact point for medical care, especially among pregnant women. Research has demonstrated that CHPs make a great impact on healthcare delivery in Nigeria, especially in maternal and child health, disease prevention, and chronic diseases.²⁶

Understanding the factors that influence the use of these services is essential for designing targeted interventions. This study aimed to address this knowledge gap by examining the determinants of Community Health Extension Services as experienced and implemented by Community Health Practitioners in Ebonyi State, offering insights that could guide more effective and responsive healthcare strategies.

RESEARCH METHODOLOGY

3.1 Study Design

The study adopted a descriptive cross-sectional study design to investigate the determinants of community health extension services provided by Community Health Practitioners in Ebonyi State, Nigeria. A total of 385 community health practitioners were recruited from the three zones of the state.

3.2 Sample Size Determination

Sample size used was obtained using the descriptive studies sample size determination formula, by Cochran

$$n = \frac{Z^2 pq}{e^2}$$

Where;

n = Sample size to be obtained

Z = the normal curve, 1.96 at 95% Confidence Interval

e = margin of precision (5%) = 0.05

p = estimated proportion of the population (e.g., 0.5 for a rough estimate)

100-p = q

$$\text{Sample size (n)} = \frac{1.96^2(0.5(1-0.5))}{0.05^2}$$

$$\begin{aligned} n &= \frac{3.8416(0.5(0.5))}{0.0025} \\ n &= \frac{3.8416(0.25)}{0.0025} \\ n &= \frac{0.9604}{0.0025} \\ n &= 385 \\ n &= 385 \end{aligned}$$

3.3 Selection Criteria

3.3.1 Inclusion Criteria

- Community health practitioners currently employed in public health facilities in Ebonyi State
- Practitioners who had worked for at least six months in their respective facilities.
- Those who duly signed written informed consent for the study.

3.3.2 Exclusion Criteria

- Practitioners who are on leave.
- Practitioners who are less than six months of work experience.
- Practitioners who declined informed consent.

3.4 Sampling Technique

Simple Random Sampling method was used in the study. The method was used to select two (2) LGAs from each of the senatorial zones, making a total of six (6) LGAs to be studied. The selected LGAs included Izzi and Ohaukwu from Ebonyi North, Ikwo and Ishielu from Ebonyi Central, and Afikpo North and Ohaozara from Ebonyi South senatorial zone. Simple Random Sampling was also used to select about 50 respondents from the register of the association in the selected LGA. This was done in order to obtain a total of 385 Community Health Practitioners who acted as the respondents of this study.

3.5 Instrument for Data Collection

The research tool that was used in the study is a structured questionnaire. It was validated by three experts in the field of study and the research supervisor. It consists of four (4) sections comprising section A as the socio-demographic data and the three (3) research objectives of the study, Section B obtained responses on knowledge, section C obtained responses from attitude, and section D obtained responses from practice.

3.6 Reliability of the Instrument

To ensure the instrument's reliability, a pilot study was conducted in Enugu State's primary care facilities. Initially, 30 practitioners at these centres completed the instrument, which was then collected and analyzed. After a two-week interval, the researcher returned to the same facilities and asked another group of 30 practitioners to complete the instrument. Once again, the responses were collected and examined. The correlation between the two sets of results was strong, at 0.85, indicating a consistent relationship with the first administration. This finding confirms that the instrument demonstrates a high level of reliability.

3.7 Statistical Analysis

The data collected were analysed using Statistical Package for Social Sciences (SPSS) version 26.0. Descriptive statistics including frequencies and percentages and inferential statistics using Chi-square and odd ratio were used. Statistical significance was set at $p < 0.05$.

RESULTS AND DISCUSSION

Response Rate/Completeness of Data

A total of 300 questionnaires were administered to Local health staff, a total of 296 of the questionnaires were retrieved and used for the analysis. This gave a response rate of 98.7% There was no missing data, only completely filled questionnaires were used for the analysis, hence 100% completeness of data was obtained.

Table 4.1: Socio-Demographic Characteristics of Respondents

Variables	Frequency (n=296)	Percentage (%)
Age (Years)		
15-25 yrs	67	22.6
26-35 yrs	126	42.6
36-45 yrs	103	34.8
Sex		
Male	81	27.4
Female	215	72.6
Marital status		
Single	57	19.3
Married	239	80.7
Carder		
JCHEW	57	19.3
CHEW	140	47.3
CHO	61	20.6
PHCT	38	12.8
Religion		
Christianity	283	95.6
Others	13	4.4

Table 4.2: Knowledge of Community Health Extension Services

Variables	Yes n(%)	No n(%)
Community Health Extension Services are Primary Health Care Services provided to individuals where they live and work.	289(97.6)	7(2.4)
What are the objectives of Community Health Extension Services?		
To improve health outcomes	296(100.0)	-
To increase access to healthcare	296(100.0)	-
To promote health education	296(100.0)	-
The different services provided during Community Health Extension Services are		
Maternal and child health services	296(100.0)	-
Family planning services	296(100.0)	-
Immunization services	289(97.6)	7(2.4)
Disease prevention services	274(92.6)	22(7.4)
Disease control services	274(92.6)	22(7.4)
Health education services	296(100.0)	-

Table 4.3: Assessment of Knowledge of Community Health Extension Services

Variables	Frequency (n=296)	Percentage (%)
Level of Knowledge		
Good	274	92.6
Poor	22	7.4
Total	296	100.0

Table 4.4.: Attitude towards Community Health Extension Services

Variables	Strongly Agree (5)	Agree (4)	Indifferent (3)	Disagree (2)	Strongly Disagree (1)
Feel good about providing Community Health Extension Services.	289(97.6)	7(2.4)	-	-	-
Community Health Extension Services are important for improving health outcomes in your community.	259(87.5)	37(12.5)	-	-	-
Willing to participate in training programs to improve your skills in providing Community Health Extension Services.	259(87.5)	37(12.5)	-	-	-
Willing to train others to improve their knowledge and skills necessary for providing Community Health Extension Services.	244(82.4)	45(15.2)	7(2.4)	-	-
Importance of Community Health Extension Services is rated high as you work as a Community Health Practitioner.	198(66.9)	91(30.7)	7(2.4)	-	-

Table 4.5: Assessment of Attitude towards Community Health Extension Services

Variables	Frequency (n=296)	Percentage (%)
Level of Attitude		
Positive	259	87.5
Negative	37	12.5
Total	296	100.0

Table 4.8: Association between socio-demographics and knowledge of Community Health
Extension Services

Variables	Knowledge X ²			Odd ratio (OR)	
	Good (n(%))	Poor (n(%))	Total	d f (p-value)	95% (CI)
Age (years)					
≤35yrs	178(92.2)	15(7.8)	193(100)	1	0.093
≥36yrs	96(93.2)	7(6.8)	103(100.0)	(0.760)	(0.341-2.195)
Sex					
Male	81(100)	0(0.0)	81(100)	1	15.931
Female	178(82.8)	37(17.2)	215(100)	(0.001) *	(1.136-1.284)
Marital Status					
Married	50(87.7)	7(12.3)	57(100.0)	1	2.412
Separated	224(93.7)	15(6.3)	239(100.0)	(0.120)	(0.185-1.234)
Cadre					
JCHEW	50(87.7)	7(12.3)	57(100.0)	4	
CHEW	132(94.3)	8(5.7)	140(100.0)		14.115
CHO	61(100)	0(0.0)	61(100.0)		(0.003) *
PHCT	31(81.6)	7(18.4)	38(100.0)		
Religion					
Christianity	261(92.2)	22(7.8)	283(100.0)		1.092
Others	13(100)	0(0.0)	13(100.0)	1	(0.296)

P≤0.05 (statistically significant), Fischer's exact

Table 4.9: Association between socio-demographics and attitude towards Community Health
Extension Services

Variables	AttitudeX ²			Odd ratio (OR)		
	Positive (n(%))	Negative (n(%))	Total	d f	(p-value)	95% (CI)
Age (years)						
≤35yrs	164(85.0)	29(15.0)	193(100)	1	3.235	0.476
≥36yrs	95(92.2)	8(7.8)	103(100.0)		(0.072)	(0.209-1.084)
Sex						
Male	81(100)	0(0.0)	81(100)	1	15.931	1.208
Female	178(82.8)	37(17.2)	215(100)		(0.001) *	(1.136-1.284)
Marital Status						
Married	50(87.7)	7(12.3)	57(100.0)	1	0.003	1.025
Separated	209(87.4)	30(9.3)	239(100.0)		(0.956)	(.0425-2.469)
Cadre						
JCHEW	50(87.7)	7(12.3)	57(100.0)	4		
CHEW	125(89.3)	15(10.7)	140(100.0)		3.011	-
CHO	54(88.5)	7(11.5)	61(100.0)		(0.390)	
PHCT	30(78.9)	8(21.1)	38(100.0)			
Religion						
Christianity	246(86.9)	37(7.8)	283(100.0)		1.942	0.869
Others	13(100)	0(0.0)	13(100.0)	1	(0.163)	(0.831-0.909)

P≤0.05 (statistically significant), Fischer's exact

DISCUSSION

The present study found that the larger share of respondents had a good knowledge of Community Health Extension Services (CHES). More specifically, it was found that a high percentage of participants, i.e., 92.6%, had a good knowledge of the various services provided, such as maternal and child health services, family planning, immunization, disease prevention and control, and health education. In addition, it was found that almost all the participants, i.e., 97.6 to 100%, had a good knowledge of the fact that CHES are a part of Primary Health Care (PHC) and are intended to improve health, provide access to health, and promote health education.

This finding is similar to, but also extends beyond, previous studies done in similar community health settings, especially in Ethiopia and Nigeria. This finding is similar to, but also extends beyond, previous studies done in similar community health settings, especially in Ethiopia and Nigeria. The findings of ³¹, who examined community knowledge of health extension programs in East Hararghe Zone, Ethiopia, with a focus on integrated disease management, revealed that 92.7% of respondents demonstrated good knowledge of HIV/AIDS, while 43% demonstrated good knowledge of malaria. Although there was a similar proportion of respondents demonstrating good knowledge of HIV/AIDS, as found in this current study (92.6%), knowledge of malaria was low compared to this current study.

This could be attributed to differences in the emphasis placed on health education, disease prevalence, and program implementation. In Nigeria, the CHES programs could have had extensive community participation and a well-structured health education component, thus explaining the high levels of awareness. In addition, literacy was a significant predictor for knowledge, as shown in ³¹, indicating the importance of education in knowledge dissemination, a notion supported by the present study, where respondents who had primary education had high levels of awareness and utilization of health services. In South Ethiopia, ³² found that 67.4% of the respondents were satisfied with urban health extension services, and this was related to technical competency, relationships, and accessibility.

Although their study was based on satisfaction rather than knowledge, it complements the findings of the present study. Knowledge of CHES in the present study could have resulted in a high level of satisfaction with community services, as knowledge often generates trust and confidence in health services. Both studies emphasize the significance of relationships in the delivery of health services to the community. In the present study, a higher percentage of knowledge was recorded than the percentage of satisfaction in ³² study, indicating that knowledge and satisfaction are two different aspects. Factors such as resource availability and staff competency are essential in determining community satisfaction.

This is supported by ³³, who evaluated the health post preparedness and service readiness in the four Ethiopian regions and found a general service readiness index of over half. While a percentage of the health posts had basic amenities, less than half maintained infection prevention standards, and over half had essential medicines in stock. Compared to the findings of the current study, which found very high knowledge levels in the community, the Ethiopian context found moderate system readiness. This could imply that knowledge in the community may be higher than the system's readiness, which could affect satisfaction in the long term.

Further, ³⁴ investigated the role of CHWs in the management of hypertension among hypertensive patients in Nigeria and found that only one-third of the CHWs had the ability to correctly diagnose hypertension, and very few had the appropriate knowledge of the investigations needed at the baseline. In the present study, it was found that nearly all the respondents had extensive knowledge of the roles and services provided by CHES, indicating

better knowledge at the community level than among CHWs, especially in specific areas like the management of hypertension. Although CHES cover all preventive and promotive health activities, which are well disseminated, the management of specific health conditions like hypertension may require specific training and CPD.

Thus, the current study findings by ³⁴ emphasize the need to enhance capacity building for health workers to match the increasing awareness of health services in the community. Thus, the current study findings are in agreement with the findings of previous studies, which showed positive community awareness and utilization of health extension services. Although knowledge levels are high, system readiness and quality are inconsistent, as shown in ³³. Education and literacy are still important factors in influencing community knowledge and utilization of health extension services, as shown in ³¹. Satisfaction and utilization of health extension services are not only influenced by awareness but also by accessibility, competency, and quality of communication, as shown in ³². There is also a knowledge gap with regard to the technical capacity of CHWs in particular service areas, as revealed by ³⁴. Lastly, while the present study has revealed satisfactory knowledge and awareness levels with regard to CHES, it is important to note that to ensure improved community health outcomes, it is essential to continue investing in the training of the staff, the preparedness of the systems, as well as the enhancement of the quality of services.

The present study found that the larger share of respondents showed a positive attitude towards Community Health Extension Services (CHES). More specifically, of the participants reported that they felt good about providing CHES, while agreed that CHES is important to improve community health outcomes. The larger share of respondents also reported that they were willing to participate in training and to train others. In summary, the larger share of respondents showed a positive attitude towards CHES, while only had a negative attitude. The present study indicates that the workforce is enthusiastic and motivated to work with the community to improve health outcomes and is open to training to enhance their capacities.

On the other hand, when the current study is compared to other relevant studies conducted in different contexts, some similarities and differences in relation to the attitudes, motivation, and satisfaction of health workers can be observed. For instance, a study conducted by ³⁵ explored the level of awareness and attitude of contracted service (CS) among general medical practitioners in urban China. The study found that the level of awareness of the importance of the work of the health practitioners was very high, at 86.01%, particularly in relation to the feeling of self-worth. This is similar to the current study, where the majority of the CHES practitioners (97.6%) felt good about the services they provided. However, whereas the current study found a very positive attitude among health workers in relation to the willingness to participate in further training, the study by ³⁵ found that work pressure and fatigue affected the satisfaction of the health workers significantly, where over 30% of the family doctors experienced a heavy work pressure, and half of the doctors were thinking of changing jobs. On the other hand, the results obtained in the current study indicate that enthusiasm and commitment are sustained, and this could explain the difference in terms of the level of perceived burnout or satisfaction with the role in community engagement for CHES workers in the context of Nigeria, compared with the results obtained in the context of China. The difference could be explained in terms of the nature and level of workload, expectations, and health system organization, with the CHES model in Nigeria being community-driven and having flexible models, compared with the more demanding and performance-driven model in China. The study conducted by ³⁶ aimed to explore knowledge, attitude, and practice regarding sexually transmitted infections (STIs) among women of reproductive age in Indonesia. The results indicated that 88% had positive attitudes, similar to the positive attitude obtained in the current study.

This consistency reinforces the idea that positive attitudes toward community health initiatives, both in relation to CHES and STI prevention, are shaped by awareness, relevance, and information access. Furthermore, education level was identified by ³⁶ as a predictor for knowledge and attitude, a similar theme to the present study, where the willingness to participate in further education points to the importance of education and skills development for positive attitudes and service delivery. In addition, although the study by ³⁶ centred on community attitudes toward health services, the present study centres on the professional attitude of health workers, their commitment to service delivery and community health improvement.

The study by ³⁷ sought to examine the existence and delivery of sexual and reproductive health services in primary healthcare centres in Ebonyi State, Nigeria. From the study, it was evident that most of the workers had been trained for the purpose, and over 95% claimed to give equitable treatment to all clients, regardless of age or gender. These two studies seem to align well with the current study's emphasis on positive professional attitude and willingness to train or mentor others. Both studies emphasize the need for training and skills enhancement for Local health staff.

This study extends the above by indicating that the respondents not only value CHES as essential for improving health outcomes but are also eager to share their knowledge and enhance the skills of others, indicating a culture of continuous learning and empowerment among peers. Although ³⁷ focused their attention on SRH service provision among trained CHWs, the present study adopts a broader perspective of CHES, including preventive, promotive, and educational health services. This shows that positive attitudes are universal across different areas of primary health care, especially if training, supervision, and role clarity are prioritized. Finally, the comparison of the present study with the previous literature shows the following key insights: In all the studies carried out by different researchers, such as ³⁵ ³⁶ and ³⁷ it was observed that the majority of health professionals or community members showed positive attitudes towards health services, as observed in the present study with 87.5% positive attitude.

This is a reflection of a wider recognition of the significance of health extension and community-based interventions. Both the present and previous study have highlighted the significance of education and training in influencing attitudes and performance. Continuous education and training not only improve performance but also reinforce professional motivation and satisfaction. Contrary to the experience of ³⁵ where work pressure and burnout were major obstacles to positive attitude maintenance, the present study points to a greater sense of job satisfaction and professional pride among CHES providers. The study's results, in terms of willingness to train others and participate in community development, are consistent with ³⁷. Once again, this demonstrates a common interest in improving community health outcomes and mentoring less experienced colleagues. Finally, the results of the current study are consistent with previous research in demonstrating high levels of motivation and positive attitudes among health practitioners involved in community-based health programs. In addition, however, the results of the current study demonstrate an exceptional level of personal fulfillment, willingness to learn, and commitment to mentorship, which could be critical assets for the sustainability and expansion of CHES programs. Overall, the results of the study highlight the significance of ongoing training, supervisory support, and workload management in maintaining these positive attitudes and translating them into improved quality and accessibility of community health services.

Conclusions

The study found that the knowledge, attitude, and practice of the Community Health Practitioners towards the provision of Community Health Extension Services (CHES) were commendable. Most of the practitioners had a clear knowledge of the objectives and scope of CHES as a key component of Primary Health Care (PHC), which included health promotion, disease prevention, maternal and child health, family planning, and health education.

This level of knowledge was matched by a positive attitude, where the practitioners were found to be satisfied with the provision of CHES, saw the importance of CHES in improving health outcomes, and were willing to be trained further and train others in the provision of CHES.

Furthermore, the findings showed that the practitioners were actively engaged in the practical implementation of a wide range of CHES components, which included immunization, treatment of minor ailments, family planning, rehabilitation, data collection, and community mobilization. This showed a strong sense of professional commitment and a clear alignment with the objectives of primary health care. However, despite the existence of these attributes, the study also found several key challenges that affect the effective implementation of CHES. These challenges included lack of funding and logistics, poor road infrastructure, language and cultural barriers, lack of stakeholder support, poor political interest, and poor digital connectivity. All these challenges affect the realization of the CHES objectives and the sustainability of health service delivery in the community.

Conclusively, therefore, while the Community Health Practitioners demonstrate remarkable competence and passion in the delivery of CHES, the need to address the operational challenges they face through the enhancement of funding systems, logistics, stakeholder participation, and digital communication networks is a matter of urgency. This will help in the enhancement of the efficiency and efficacy of the Community Health Extension Service in the advancement of community health. Overall, the findings suggest the need to address the professional and gender-based strategies that take into consideration the various demographic factors affecting the knowledge, attitudes, and practices of health workers. Capacity-building programs may be beneficial in the enhancement of the efficacy of the Community Health Extension Service.

Recommendations

Targeted interventions that will strengthen the implementation and sustainability of Community Health Extension Services (CHES) such as; Strengthen Funding and Resource Allocation, Improve Infrastructure and Logistics, Enhance Training and Capacity Building, Promote Stakeholder and Political Engagement, Integrate Technology and Improve Connectivity, Encourage Community Participation and Ownership.

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Ethical Approval

Ethical clearance was obtained from the Ethics Committee and Research Management and Development with the approved number: UPH/CEREMAD/MM111/09

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