

International Journal of Health, Medicine and Nursing Practice


(IJHMNP)

Barriers to access and utilization of health services
among marginalized communities in sub-Saharan
African countries: Scoping review



CARI
Journals

Barriers to access and utilization of health services among marginalized communities in sub-Saharan African countries: Scoping review

 Theoneste Nteziryayo^{1*}, Robert K Basaza², Humphrey C Karamagi³, Prossy K Namyalo⁴

^{1*}Health System Strengthening Cluster, World Health Organization, Congo Republic

²School of Public Health, Uganda Christian University, Mukono, Uganda

³World Health Organization – AFRO, Brazzaville, Congo

⁴School of Social Sciences, Ndejje University, Kampala, Uganda

<https://orcid.org/0009-0001-9730-7273>

Accepted: 14th Mar, 2024 Received in Revised Form: 14th Apr, 2024 Published: 14th May, 2024

Abstract

Purpose: This scoping review aimed to investigate the barriers encountered by marginalized communities in sub-Saharan African countries when accessing and utilizing healthcare services.

Methodology: The scoping review was evaluated through online databases like the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and SCOPUS review according to the barriers to accessing and utilizing health services among marginalized communities in sub-Saharan African countries. The scoping review identifies the articles from the topic through the online databases using the including and excluding criteria.

Findings: The findings identified the barriers to healthcare access, lack of communication and language, and not sharing the proper health details with the healthcare professional. The findings also demonstrated the implications and consequences such as health disparities, economic burden, social and human rights implications, loss of productivity and development, public health implications, and reinforcing social exclusion.

Unique contribution to theory, practice and policy: This scoping review illuminates the intricate nexus of socio-economic factors, cultural dynamics, and human rights awareness as barriers to healthcare access in sub-Saharan Africa. The findings offer actionable insights for healthcare practitioners to customize services for marginalized communities, addressing communication gaps and information-sharing reluctance. Moreover, policymakers can utilize these insights to advocate evidence-based policies aimed at promoting equitable healthcare access and enhancing health literacy. Thus, this research serves as a vital conduit between theoretical understanding, practical application, and policy formulation, facilitating the advancement of inclusive and equitable healthcare delivery in the region.

Keywords: *Barriers, Health services, Knowledge, Community people*

1. INTRODUCTION

The main goal of a healthcare system is to facilitate the effective utilization of evidence-based interventions that respond to the individual and group health and well-being expectations for the beneficiary population. Access to these effective health interventions is one of the drivers of a functional health system [1]. However, since 2020, access to these essential health services has faced previously unheard-of hurdles driven by the response to the coronavirus disease (COVID-19) pandemic [2,3].

The current global focus on the attainment of Universal Health Coverage (UHC) implies the need to expand access to essential services in a manner that leaves no one behind [14]. However, the populations in Africa face multiple vulnerabilities that make this difficult. As a result, there are multiple populations considered marginalized, such as a variety of ethnic minorities, indigenous peoples, rural populations, women, children, people with disabilities, and poor people. These groups frequently experience many forms of marginalisation that interact with one another, making it even harder for them to receive healthcare services. This has contributed to the persisting inequalities in health outcomes across the region, even when access to services has been improved [15].

This scoping review study aims to identify and analyse the barriers that marginalised people face while trying to access and make use of healthcare services in sub-Saharan African nations. We want to provide a thorough understanding of the barriers to healthcare access and utilization for these populations by synthesizing the available literature on the subject. Policymakers, healthcare professionals, and other stakeholders will benefit from the findings of this analysis as they design focused efforts to remove these obstacles and support equitable access to healing cross-cutting healthcare services.

2. LITERATURE REVIEW

To alleviate health inequalities and comprehend the realities of socially disadvantaged groups, marginalized communities must be defined. To give readers a thorough grasp of the definition of marginalized populations, their features, and the causes of their marginalization, this review of the literature examines the body of available research.

2.1 History of Community Engagement in Health with Marginalized Populations: Political and Social Trends

The need for community engagement with marginalized communities has been affected by significant movements in politics and society in the 1970s and 1980s. The interest in the influence of community-specific variables on health [16], the growing disparities in population health [17],

and public demands for health professionals and policymakers to be more responsive to the demands of marginalized populations have all contributed to these trends [18].

2.2 Definition of Marginalized Communities

Diverse groups that face social, economic, and political exclusion and are thus excluded from society's mainstream comprise marginalized communities. In sub-Saharan African countries, there are a variety of marginalized communities who have poor access to resources and suffer from social marginalization. These groups include indigenous peoples, ethnic and racial minorities, the poor, the disabled, and those who experience prejudice due to their gender, sexual orientation, or immigration status [25]. Marginalization acknowledges the structural obstacles and power disparities that restrict marginalized groups' access to opportunities, resources, and rights [26].

2.3 Strategies to Improve Healthcare Access

A thorough and varied approach is needed to address healthcare access gaps among marginalized communities. Access to healthcare services can be improved by the implementation of financial protection measures and other policy initiatives [31]. To improve access and guarantee the availability of high-quality care, healthcare infrastructure must be strengthened, especially in underserved areas [32].

2.4 Intersectionality and Marginalization

Recognizing intersectionality is crucial to defining marginalized communities. Because of the intersecting oppressive systems that people must contend with, intersectionality recognizes that people may suffer numerous forms of marginalization at once. Intersectionality draws attention to the nuanced interactions of racial, gender, class, and other identities in how marginalization is experienced by people. People who are members of marginalized racial or ethnic groups and also endure discrimination based on their gender or sexual orientation, for instance, may encounter particular difficulties and compounded disadvantages [36].

2.5 Healthcare Systems in Sub-Saharan Africa

The disparity in access to healthcare between Africa and the rest of the world is persistently widening. 11 percent of the world's population and 24 percent of the burden of disease are shared by Sub-Saharan Africa (SSA). However, only one percent of all health spending is spent in this portion of the world. Over the past ten years, SSA has received financial aid totaling over eight billion dollars as part of a healthcare improvement program. Rural residents suffer and are victims of inadequate medical facilities, personnel, and pharmaceutical access [37]. The largest Ebola outbreak in West Africa has brought attention to the flaws and shortcomings of the healthcare systems in Sub-Saharan Africa. While Mali, Nigeria, and Senegal were able to successfully manage

the epidemic, other nations like Guinea, Liberia, and Sierra Leone severely relied on aid from abroad. Along with the one-sided benefit of international aid for the economic development of research partnership to the donor rather than the recipient, the urgent need for capacity building and capacity enablement is stressed [38].

3. METHODOLOGY

3.1 Research question and approach

The review was guided by the research question “What are the barriers that marginalized people face while trying to access and make use of healthcare services in sub-Saharan African nations?”. Using the Arksey and O’Melley scoping review framework, this review involved five stages; i) identifying the research questions, ii) identifying relevant studies, iii) study selections, iv) charting the data, and v) collecting, summarizing and reporting the results [41]. We also adhered to the extension for reporting scoping review guidelines by Preferred Reporting Items for Systematic Reviews and Meta-Analyses [42].

3.2 Data Sources and Search

Using the search strategy, we searched Google Scholar, PubMed, CINAHL, Global Health, Medline and Embase between March to October 2023. We used search terms like "African children's healthcare access," "barriers and facilitators to healthcare access," "barrier to healthcare access", "Africa", "AFRO", "accessibility to healthcare," "health services," "medical care," "vulnerable populations" and "facilitators to healthcare access.". The Boolean operators "AND" and "OR" were used to combine these keywords to find a wide range of publications.

3.3 Eligibility criteria

We used Population, Concept, and Context (PPC) (Peters et al 2017) to include studies in this review. Marginalized communities were the target population, the concept was their barriers to access and utilization of health services within the African regions. Therefore, we included studies from 15 articles. The scoping review focused on countries in Africa spending US\$ 50 or below per annum as Total Health expenditure. Articles that addressed problems with African children's access to healthcare were included under the inclusion criteria. 152 duplicated articles were eliminated by using DOI. In the excluded criteria 275 articles were published before 2017, and 12 articles from CINAHL, Global Health, Medline and Embase contained irrelevant data that did not concentrate on this particular population or topic and were eliminated by the researchers. The precise criteria were created to guarantee the articles chosen were relevant. Regarding the language restrictions, the researchers only included articles published in the English language. The selected articles from Google Scholar and Pubmed data sources were merged with the endnotes, and duplicated items

were removed.

3.4 Study selection and data extraction

The search and articles collected from online databases yielded 466 (PRISMA - Figure 1) and after title abstract and full-text screening, 15 studies were eligible for inclusion. We designed an Excel sheet to extract the data and two reviewers (14 articles) extracted the data from key findings and facts of the included studies. Disagreements were resolved through discussion and conscience. We extracted the data on several aspects including authors, year of publication, and research objectives as per the data collection of healthcare service access in Africa. The next level of extracting the complete information from the remaining included articles like the aim of the study, research objective, inclusion data criteria, sample size, research method, the survey, and results according to the barriers and facilitators in the healthcare services. After scrutinizing the articles, we accumulated the findings into the barriers to Healthcare access, Implications and Consequences like health disparities, Economic burden, social and human rights implications, loss of development, public health, and reinforcing social exclusion.

64. RESULT

4.1 Study screening result

A total of 466 articles were found to be applied in the endnote using a manual search. In the first level of the screening test related to the title and abstract content, 314 were selected, and for the full-text examination in the journal, 27 were eligible for the test, and then 12 articles were excluded. Finally, in the Scopus review of the journals, 15 papers are selected using qualitative and quantitative study analysis of the included criteria in the given Figure 1.

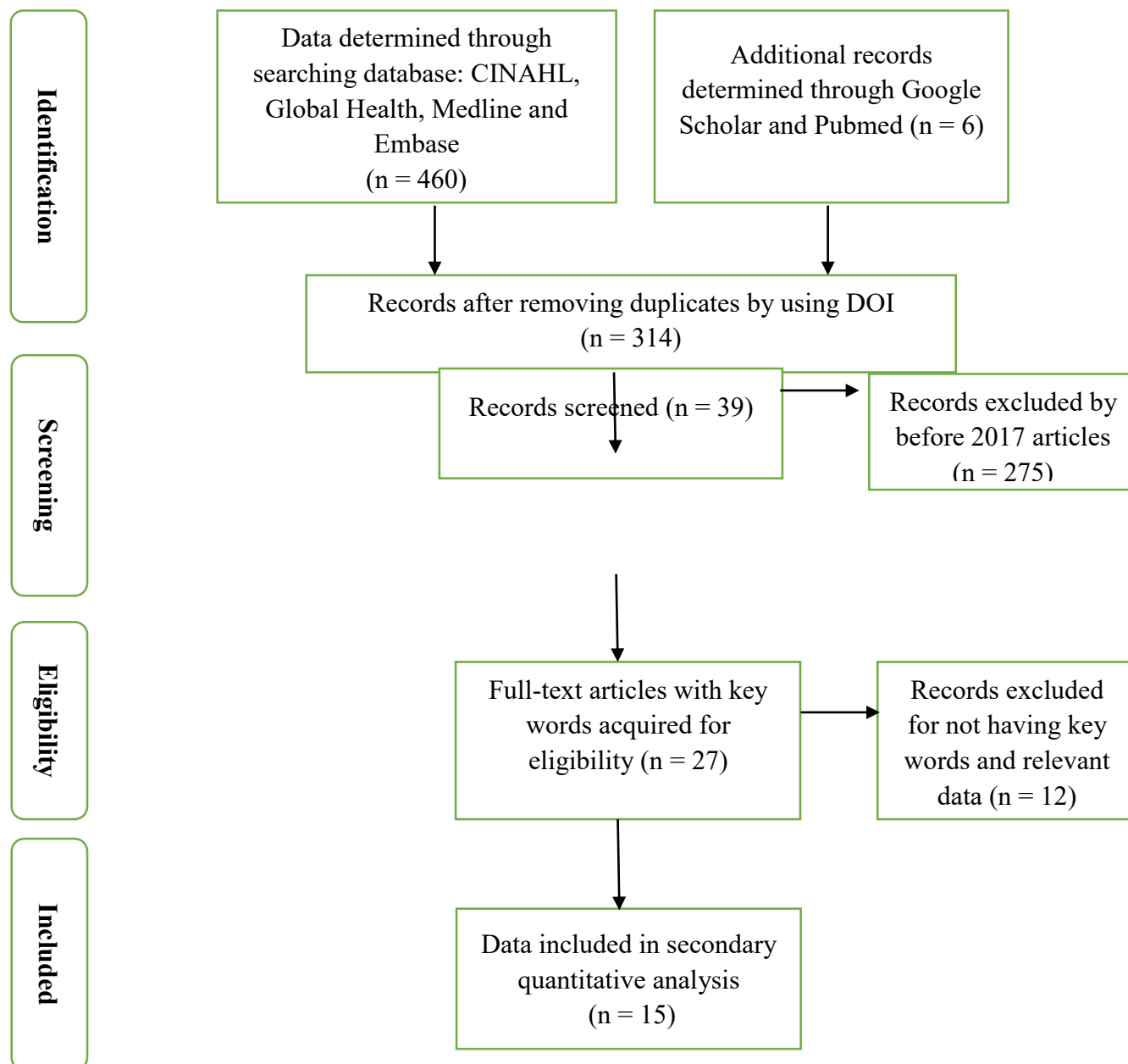


Figure 1: Flowchart of PRISMA Model

5. FINDINGS

In the selected countries, the fundamental human right to access healthcare faces many difficulties in accessing and using healthcare services effectively. These difficulties lead to poor health results and inequalities between social and economic status.

The research aims to provide the existing barriers to healthcare access and key factors of marginalized communities to use healthcare services in sub-Saharan countries.

The previous and current study explained that comparing the highlighted areas improves

the novel sight of the healthcare services in the country. It mainly found the challenges of social-cultural factors, socioeconomic status, lack of infrastructural facilities, inequity and prejudice, and awareness of health-related issues in the existing literature. The review exposed the poor income of the people and poverty issues, making it difficult to use healthcare services in the country's population. A cultural and regional attitude and untrust of the healthcare system formally reported that affecting the behaviour to taking the healthcare services in the country. The infrastructure and geographic facilities should not maintain the healthcare service in remote and rural areas. The improper transport facility in remote locations makes humans suffer many difficulties and not reach a healthcare service centre properly during an emergency, to the unequal treatment in the healthcare service for the poor people in the marginalized community of the country. Many people are affected by the disparity of the treatment in healthcare access in the marginalized community, causing fatality. In the geographic scope of the study, the people need the specific intervention of the social, cultural, and systematic factors of the therapeutic practices, lack of communication in the language, and lack of education in health wellness.

The research mainly focused on the importance of health education and awareness of health-related problems to the marginalized community populace in the sub-Saharan country. The critical factors collected from the prior studies are the lack of health education and improper sharing of health details. The intervention of the authorities explains the role of health education in enhancing marginalized communities and effectively improving the decision-making in healthcare services. The Current literature aligns the understanding of the barriers and identifies the gap in healthcare access and usage of services in the sub-Saharan region. The existing literature describes the individual people's barriers to healthcare access services, and the scoping review of the articles gives proof. By comparing the existing literature review, healthcare service providers have consistency and proper knowledge of accessing and utilizing healthcare services for marginalized communities. The scoping review findings provide a new idea of the informed policy by building the structure of the healthcare services to improve the community's healthcare access services and usage in sub-Saharan Africa.

5.1 Barriers to healthcare Access

The findings disclosed the obstructing challenges in healthcare access in the marginalized community of the sub-Saharan region. The included studies in the scoping review showed barriers of socioeconomic status, social-cultural factors, infrastructure facilities, geographic conditions, and healthcare service welfare. It causes inequality between the people, unequal treatment, inadequate transport facilities in remote areas, disparity of human rights, and lack of health education and awareness of health problems.

The socioeconomic factor is the essential barrier to the marginalized community's access to healthcare services. Poverty and limited economic resources are the main problems of the community. People have to pay huge amounts of admission and transportation costs from the less income for the necessary general healthcare services. Health insurance and social protection schemes are helpful for the less-low-income marginalized communities in African countries.

Tadesse et al [43] defined that cultural and social factors played a main role in searching healthcare behaviour in the marginalized population. The individual influenced cultural practices and thought in the decision-making in professional health care services. The common challenges in the factor are the accusation linked with certain health conditions to belief in the traditional trust and lack of confidence in the formal healthcare system [44,45].

Bertone et al. [46] studied that geographic and infrastructural obstacles affect healthcare access and services in the community to the defined boundary of the limited access and availability of resources in healthcare facilities, specifically in rural and remote locations. The lack of transport facilities to travel the long distance to admit to the healthcare centre and the shortage of care providers in healthcare services increased the difficulties in remote areas for the marginalized community [47,48].

Adanu et al. [49] explored the barrier of intolerance and inequality of treatment in the healthcare structure for such a marginalized community. The people reported the knowledge of the unequal practices, rough attitude from the service provider, and dissimilar therapy due to their economic status. Unknown language and lack of communication access with healthcare providers create a problem for the patient in critical condition [50].

Amo-adjie et al. [51] discussed that health literacy and awareness of the health-related problem are essential challenges to knowing the community of people. In the marginalized population, are limited literacy about health and awareness of healthcare service access seeking at a particular time and treatment. The lack of sharing health information should culturally affect other surrounding people [52].

5.2 Implication and Consequences

The African community faces the identified difficulties to overcome with health and well-being from the particular healthcare services. The result of the challenges to individual health affects the social culture. The effective implication of the development was by improving the policy changes and highlighting the unequal treatment in the healthcare access and usage of the services [53].

5.2.1 Health Disparities

Padyab and Asamani [54] identified the health imbalance in marginalized communities due

to the lack of health literacy and limited access to the healthcare industry in the scoping review articles. It caused a delay in the diagnosis of severe health issues, leading to an increase in the fatality rate among the population and the insufficient rotation of the cycle in the social-cultural changes and economic status [55,56].

5.2.2 Economic Burden

Persons, families, and the community bear a financial price due to the hurdles that disadvantaged populations confront. Out-of-pocket medical expenses, such as commuting and service fees, can drive people farther into poverty. The financial impact also applies to the healthcare system, as insufficient access and utilization of primary care and preventive medicine activities result in greater healthcare expenses for addressing advanced and avoidable illnesses [57].

5.2.3 Social and Human Rights Implication

The limitations to medical availability and utilization that underprivileged populations face raise social equality and human rights issues. It is a breach of a person's right to wellness to refuse or restrict the availability of medical treatment based on social background, ethnic background, standing, or different factors. It causes inherent socioeconomic imbalances and fosters prejudice. Removing such obstacles is an issue of more than health fairness but also of basic rights for humans [58].

5.2.4 Loss of Productivity and Development

The consequences of inadequate healthcare access and utilization saturate the physician's profession. Whenever disadvantaged individuals do not receive prompt and adequate treatment, their work capacity may deteriorate, resulting in monetary losses at individual and societal scales. The resulting impact on social capital and income generation can hinder progress and perpetuate patterns of poverty [59].

5.2.5 Public Health Implication

Difficulties in healthcare utilization and availability in disadvantaged groups have far-reaching public health consequences. Disease prevention and management activities are hampered by the inadequate availability of medical facilities, culminating in a greater spread of infectious illnesses and a likelihood of epidemics [60]. Furthermore, medical inequalities among disadvantaged communities can add to the region's total illness weight, harming the wellness and happiness of the whole community.

5.2.6 Reinforcing social exclusion

Barriers to health access and utilization experienced by disadvantaged populations increase social exclusion and inequality. Access to health care can exacerbate the socioeconomic divide by further excluding already marginalized communities from important privileges and opportunities. It maintains a fragile process, further hindering social integration and inclusion. Targeting and reducing the recognized hurdles is critical for attaining health equity and enhancing the general well-being of underrepresented populations. Realizing the consequences of these impediments, politicians, healthcare providers, and citizens must take aggressive actions to promote reform.

It is feasible to lessen the effects of these challenges by employing context-specific actions, including bolstering the medical system in remote regions, enhancing monetary security processes, supporting cultural literacy within the medical sector, and raising the public's knowledge of health issues. These initiatives can help advance basic rights, promote social inclusion, and lessen inequality in health. Additionally, it's crucial to use an integrative strategy that considers the bigger picture of health factors and involves other parties, such as the population's own, in the design, execution, and assessment of interventions. Interaction between governments, private sector groups, healthcare professionals, and individuals is crucial for creating long-lasting solutions and resolving the structural issues that continue obstructing access to and consumption of medical facilities.

In summary, the research provided a thorough understanding of the challenges underserved groups face in sub-Saharan African countries when attempting to access and use medical facilities. The perceived barriers are multiple and complex, often influenced by social, cultural, geographical and systemic factors. Such results have significant policy and practice implications. Specific measures to improve financial security processes, cultural competence, health infrastructure and community-based health initiatives should overcome these barriers. Politicians, health professionals, and other users can help improve health access and utilization for vulnerable communities in sub-Saharan Africa, remove those barriers, and reduce health disparities [61].

6. DISCUSSION

The included research results have been synthesized, and numerous major concepts and trends were identified, illuminating the complex constraints preventing underprivileged people from accessing healthcare. The research found that sub-Saharan African groups who feel excluded have a variety of obstacles when trying to obtain and use healthcare services similar to findings from the research [61]. Socioeconomic issues like poverty and a lack of resources have become major roadblocks. Many people living in marginalized neighbourhoods find it difficult to pay for their healthcare, especially out-of-pocket fees and transport charges, associated with the findings from the research [58]. Furthermore, cultural traditions and assumptions impact how people seek

healthcare, which might cause treatments to be used improperly or slowly. The inequalities in access result from these societal variables, including prejudice, conventional medical procedures, and distrust of established medical groups. A further important hurdle that was uncovered throughout the research was geographical availability [26,51]. Numerous underprivileged populations are found in isolated or rural locations with inadequate healthcare services and infrastructure [59,60]. The difficult conditions in those regions experience is made worse by long drives to medical infrastructure, poor transportation, and a shortage of healthcare professionals were significantly mentioned in the research studies [47,48]. Legislation should focus on improving economic safety nets, including health insurance programs, to ensure that health care is affordable and accessible to underrepresented populations. Health education initiatives, local doctors, and mobile medical clinics are examples of community-based initiatives that can improve access to health care in underserved areas [31]. Improving access and utilization requires strengthening basic healthcare structures, enhancing infrastructure, and ensuring adequate staffing. Involving disadvantaged people in decision-making processes and ensuring their participation in health policy and program formulation are important steps to empower these groups were significantly related to the studies [44,45]. To remove barriers and promote equitable access to health services, community engagement, cultural awareness, and establishing trust measures between health practitioners and underrepresented communities are essential.

7. CONCLUSION

The comprehensive research on obstacles to obtaining and using healthcare services from disadvantaged people in sub-Saharan African nations has shed important light on the difficulties that these communities experience and the consequences for their physical and mental well-being. Moreover, it was determined that major hurdles preventing disadvantaged people from receiving therapy include unfair practices and treatment among hospitals and clinics. Linguistic obstacles, prejudiced views, and a lack of racial competency among medical professionals hamper the accessibility to sufficient treatment. Such barriers have a severe negative impact on underprivileged populations in sub-Saharan Africa. Lack of accessibility to medical treatment causes illnesses to advance more slowly, treatments to take longer, and rates of sickness and fatal injuries continue to rise. Marginalized groups continued to experience more negative health effects than the overall population, reinforcing current gaps. The assessment highlights the urgent requirement for focused efforts to remove these obstacles and raise healthcare fairness. Politicians, healthcare professionals, and other stakeholders must emphasize the creation and use of evidence-based initiatives to deal with these issues.

8. RECOMMENDATIONS

Although this comprehensive review has provided insightful information, gaps in the body of literature call for further research. Future studies should examine the effects of specific programs targeting disadvantaged groups, evaluate the success of policy changes, and examine how gender affects access to health care. Research should consider the ethnic, religious and cultural characteristics of diverse marginalized communities in sub-Saharan Africa to develop context-specific strategies. Disadvantaged groups in sub-Saharan African countries must overcome many barriers. Access to and use of health services is emphasized through this comprehensive review. Socioeconomic, cultural, regional, and health system-related variables all influence these barriers. Government officials, medical personnel, and other involved parties may aid in lowering health inequalities and enhancing the general well-being of the region's underprivileged communities by tackling these obstacles and advancing health equality. To guarantee equal and open utilization of medical for all, further study is required, as well as joint initiatives.

References

1. Karamagi HC, Tumusiime P, Titi-Ofei R, Droti B, Kipruto H, Nabyonga-Orem J, Seydi AB, Zawaira F, Schmets G, Cabore JW. Towards universal health coverage in the WHO African Region: assessing health system functionality, incorporating lessons from COVID-19. *BMJ global health*. 2021 Mar 1;6(3):e004618.
2. Singh DR, Sunuwar DR, Shah SK, Karki K, Sah LK, Adhikari B, Sah RK. Impact of COVID-19 on health services utilization in Province-2 of Nepal: a qualitative study among community members and stakeholders. *BMC health services research*. 2021 Dec;21(1):1
3. Moynihan R, Sanders S, Michaleff ZA, Scott AM, Clark J, To EJ, Jones M, Kitchener E, Fox M, Johansson M, Lang E. Impact of COVID-19 pandemic on utilisation of healthcare services: a systematic review. *BMJ open*. 2021 Mar 1;11(3):e045343.
4. WHO, Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021: Interim report, 7 February 2022 [Internet]. World Health Organization; 2022 [cited 2023 Aug 29]. Available from: <https://apps.who.int/iris/handle/10665/351527>.
5. Mhango M, Chitungo I, Dzinamarira T. COVID-19 lockdowns: impact on facility-based HIV testing and the case for the scaling up of home-based testing services in sub-Saharan Africa. *AIDS and Behavior*. 2020 Nov;24:3014-6.
6. Murewanhema G, Dzinamarira T. The COVID-19 pandemic: public health responses in sub-Saharan Africa. *International Journal of Environmental Research and Public Health*. 2022 Apr

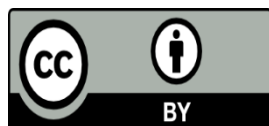
- 7;19(8):4448.
7. Tessema GA, Kinfu Y, Dachew BA, Tesema AG, Assefa Y, Alene KA, Aregay AF, Ayalew MB, Bezabhe WM, Bali AG, Dadi AF. The COVID-19 pandemic and healthcare systems in Africa: a scoping review of preparedness, impact and response. *BMJ global health*. 2021 Dec 1;6(12):e007179.
 8. Cabore JW, Karamagi HC, Kipruto HK, Mungatu JK, Asamani JA, Droti B, Titi-Ofei R, Seydi AB, Kidane SN, Balde T, Gueye AS. COVID-19 in the 47 countries of the WHO African region: a modelling analysis of past trends and future patterns. *The Lancet Global Health*. 2022 Aug 1;10(8):e1099-114.
 9. Peters DH, Garg A, Bloom G, Walker DG, Brieger WR, Hafizur Rahman M. Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences*. 2008 Jun;1136(1):161-71.
 10. Oliver A, Mossialos E. Equity of access to health care: outlining the foundations for action. *Journal of Epidemiology & Community Health*. 2004 Aug 1;58(8):655-8.
 11. O'Donnell O. Access to health care in developing countries: breaking down demand side barriers. *Cadernos de saude publica*. 2007;23:2820-34.
 12. Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. *Health policy and planning*. 2004 Mar 1;19(2):69-79.
 13. James CD, Hanson K, McPake B, Balabanova D, Gwatkin D, Hopwood I, Xu K. To retain or remove user fees? Reflections on the current debate in low-and middle-income countries. *Applied health economics and health policy*, 2006 5, 137-153.
 14. Carrin G, Mathauer I, Xu K, Evans DB. Universal coverage of health services: tailoring its implementation. *Bulletin of the World Health Organization*. 2008;86:857-63.
 15. Pérez-Mesa D, Marrero GA, Darias-Curvo S. Child health inequality in Sub-Saharan Africa. *Economics & Human Biology*. 2022 Dec 1;47:101176.
 16. Veenstra G, Lomas J. Home is where the governing is: social capital and regional health governance. *Health & Place*. 1999 Mar 1;5(1):1-2.
 17. Ritchie D, Parry O, Gnich W, Platt S. Issues of participation, ownership and empowerment in a community development programme: tackling smoking in a low-income area in Scotland. *Health Promotion International*. 2004 Mar 1;19(1):51-9.
 18. Zakus JD, Lysack CL. Revisiting community participation. *Health policy and planning*. 1998 Jan 1;13(1):1-2.

19. Konner M. *Medicine at the crossroads: The crisis in health care*. 1993
20. Rifkin SB. *Paradigms lost: toward a new understanding of community participation in health programmes*. *Acta tropica*. 1996 Apr 1;61(2):79-92.
21. Charles C, DeMaio S. Lay participation in health care decision making: a conceptual framework. *Journal of health politics, policy and law*, 1993 18(4), 881-904.
22. Lasker RD, Guidry JA. *Engaging the community in decision making: Case studies tracking participation, voice and influence*. McFarland; 2009 Jan 7.
23. Ata A. Declaration of Alma-ata. In *International conference on primary health care, Alma-Ata, USSR 1978* (Vol. 6, p. 12).
24. Kahssay HM, Oakley P, World Health Organization. *Community involvement in health development: a review of the concept and practice*. World Health Organization; 1999.
25. World Health Organization. Centre for Health Development. *Hidden cities: unmasking and overcoming health inequities in urban settings*. World Health Organization; 2010.
26. Link BG, Yang LH, Phelan JC, Collins PY. Measuring mental illness stigma. *Schizophrenia bulletin*. 2004 Jan 1;30(3):511-41.
27. Khan S, Combaz E, McAslan FE. *Social Exclusion. Topic Guide*. Birmingham, UK: GSDRC, University of Birmingham. <http://www.gsdrc.org/wp-content/uploads/2015/08/SocialExclusion.pdf>. 2015.
28. Parker R, Aggleton P. HIV-and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *InCulture, society and sexuality* 2007 Jan 24 (pp. 459-474). Routledge.
29. Jimenez DE, Park M, Rosen D, hui Joo J, Garza DM, Weinstein ER, Conner K, Silva C, Okereke O. Centering culture in mental health: Differences in diagnosis, treatment, and access to care among older people of color. *The American journal of geriatric psychiatry*. 2022 Jul 8.
30. Gruebner O, Rapp MA, Adli M, Kluge U, Galea S, Heinz A. Cities and mental health. *Deutsches Ärzteblatt International*. 2017 Feb;114(8):121.
31. Blumenthal D, Abrams M, Nuzum R. The affordable care act at 5 years. *New England Journal of Medicine*. 2015 Jun 18;372(25):2451-8.
32. Mæstad O, Mwisongo A. Informal payments and the quality of health care: mechanisms revealed by Tanzanian health workers. *Health policy*. 2011 Feb 1;99(2):107-15.
33. Brach C, Fraser I, Paez K. Crossing the language chasm. *Health Affairs*. 2005 Mar;24(2):424-

- 34.
34. World Health Organization. World Health Statistics 2019: Monitoring health for the SDGs, sustainable development goals. 2019 Retrieved from https://www.who.int/gho/publications/world_health_statistics/2019/en/
35. Mash B. African primary care research: participatory action research. *African Journal of Primary Health Care and Family Medicine*. 2014 Jan 1;6(1):1-5.
36. McIntosh ML. Compound Fractures: Healing the Intersectionality of Racism, Classism and Trauma in Schools with a Trauma-Informed Approach as Part of a Social Justice Framework. *Journal of Educational Leadership and Policy Studies*. 2019;3(1):n1.
37. Zekeng E. Healthcare systems in Sub-Saharan Africa: focusing on community-based delivery (CBD) of health services and the development of local research institutes. *United Nations Peace Progr*. 2016;3:44-9.
38. Tomori O. Will Africa's future epidemic ride on forgotten lessons from the Ebola epidemic?. *BMC medicine*. 2015 Dec;13(1):1-4.
39. Ukama P. Philanthropy as a Point of Convergence with Africa's Diaspora During the Ebola Case Study (Doctoral dissertation, University of the Witwatersrand, Faculty of Commerce, Law and Management, School of Governance and Public Leadership).2017
40. Nabyonga Orem J, Mugisha F, Kirunga C, Macq J, Criel B. Abolition of user fees: the Uganda paradox. *Health policy and planning*. 2011 Nov 1;26(suppl_2):ii41-51.
41. Arksey, H., & O'Malley, L. 2005. 'Scoping Studies: Towards a Methodological Framework', *Int. J. Social Research Methodology*, 8 (1), 19–32.
42. Tricco AC, Lillie E, Zarin W, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med* 2018;169:467–73
43. Tadesse W, Abdissa D, Tadesse Y, Demissie M. Health-seeking behavior and associated factors among rural women in Dera Woreda, Amhara Region, Ethiopia: A community-based study. *Journal of Multidisciplinary Healthcare*, 2020 13, 729-737.
44. Asamani JA., Ameme DK., Naab F, Appiah C. Barriers to access and utilization of healthcare services in Ghana: A qualitative study in a rural community. *International Journal for Equity in Health*, 2017 16(1), 204.
45. Saronga HP, Duysburgh E, Massawe S, Dalaba MA, Savadogo G, Tonchev P, Dong H, Sauerborn R, Loukanova S. Efficiency of antenatal care and childbirth services in selected primary health care facilities in rural Tanzania: a cross-sectional study. *BMC health services*

- research. 2014 Dec;14(1):1-1.
46. Bertone M P, Meessen B, Clarysse G, Hercot D. Removing user fees in the health sector: A review of policy processes in six sub-Saharan African countries. *Health Policy and Planning*, 2018 33(4), 675-692.
 47. Munga MA, Songstad NG, Blystad A, Mæstad O. The decentralisation-centralisation dilemma: recruitment and distribution of health workers in remote districts of Tanzania. *BMC international health and human rights*. 2009 Dec;9:1-1.
 48. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P. WHO European review of social determinants of health and the health divide. *The Lancet*. 2012 Sep 15;380(9846):1011-29.
 49. Adanu RM, Johnson TR. Migration and women's health. *International Journal of Gynecology & Obstetrics*. 2009 Aug 1;106(2):179-81.
 50. Mladovsky P, Allin S, Masseria C, Hernández-Quevedo C. Health in the European Union: Trends and analysis. *Observatory Studies Series No. 27*. World Health Organization 2012.
 51. Amo-Adjei J, Annim, SK, Ofori IP. Access to healthcare among persons with disabilities in Ghana. *PLOS ONE*, 2020 15(2), e0228524
 52. Elobu AE, Kintu A, Galukande M, Kaggwa S, Mijjumbi C, Tindimwebwa JV. Medical education and health care delivery in Uganda: Challenges and lessons learned. *Academic Medicine*, 2017 92(7), 935-939.
 53. Ameh S, Gomez-Olive FX, Kahn K, Tollman SM, Klipstein-Grobusch K. Predictors of health care use by adults 50 years and over in a rural South African setting. *Global health action*. 2014 Dec 1;7(1):24771.
 54. Padyab M, Asamani JA. Socioeconomic disparities in healthcare utilization among older adults in Ghana: A decomposition analysis. *BMC Public Health*, 2020 20(1), 1-12.
 55. Asiki G, Murphy G, Nakiyingi-Miiró J, Seeley J, Nsubuga RN, Karabarinde A, Waswa L, Biraro S, Kasamba I, Pomilla C, Maher D. The general population cohort in rural south-western Uganda: a platform for communicable and non-communicable disease studies. *International journal of epidemiology*. 2013 Feb 1;42(1):129-41.
 56. Gomez-Olive FX, Montana L, Wagner RG, Kabudula CW, Rohr JK., Kahn K, Berkman L. Persistent or emerging poverty and health in South Africa: A longitudinal analysis of KwaZulu-Natal, 2001-2009. *Global Health Action*, 2014 7(1), 23581.
 57. McIntyre HD, Catalano P, Zhang C, Desoye G, Mathiesen ER, Damm P. Gestational diabetes mellitus. *Nature reviews Disease primers*, 2019 5(1), p.47.

58. Ettarh RA. Patterns of international collaboration in cardiovascular research in sub-Saharan Africa. *Cardiovascular Journal of Africa*. 2016 May 1;27(3):194-200.
59. Tseng YH, Griffiths F, de Kadt J, Nxumalo N, Rwafa T, Malatji H, Goudge J. Integrating community health workers into the formal health system to improve performance: a qualitative study on the role of on-site supervision in the South African programme. *BMJ open*. 2019 Feb 1;9(2):e022186.
60. Ndlovu-Gatsheni SJ. *Decolonization, development and knowledge in Africa: Turning over a new leaf*. Routledge; 2020 Apr 30.
61. Goudge J, Gilson L, Russell S, Gumede T, Tollman S, Mills A. Illness-related impoverishment in rural South Africa: Why does social protection work for some households but not others? *Journal of International Development*, 2019 31(3), 193-212.



©2024 by the Authors. This Article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<http://creativecommons.org/licenses/by/4.0/>)