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Community Engagement versus Social Mobilization in Public Health Interventions: A Qualitative Study of Practitioners' Perceptions

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Abstract

Background: Community engagement and social mobilization are widely used strategies in public health interventions, yet limited empirical evidence exists comparing their effectiveness, sustainability, and long-term impact, particularly from practitioners' perspectives in Nigeria. This study explored practitioners' perceptions of both strategies in Minna, Niger State, Nigeria. **Methods:** A descriptive qualitative research design was adopted. Data were collected through semi-structured key informant interviews with 21 purposively selected public health practitioners from state government agencies, development partner organizations, and local government authority health departments. Data were analyzed using Braun and Clarke's six-phase thematic analysis framework with NVivo 16 software, generating six themes and twelve categories. **Results:** Practitioners described community engagement as a structured, multi-dimensional participatory process involving community participation, stakeholder involvement, gatekeeper engagement, and shared decision-making. It was perceived as important for public health intervention success and required continuous rather than episodic implementation. Reported outcomes included improved service uptake, enhanced acceptance, strengthened trust, reduced non-compliance, and community ownership. Social mobilization was viewed as effective for generating rapid awareness through diverse communication channels, but was characterized as incentive-dependent, shallow in participation, and less sustainable. Community engagement was consistently perceived as more sustainable due to stronger ownership, durable behavior change, and enhanced community agency. Both strategies were viewed as complementary. **Conclusion:** The study concludes that, from practitioners' perspectives, community engagement was perceived as more effective for long-term sustainability and behavior change, while social mobilization was valued for rapid awareness creation. Public health systems in Nigeria should institutionalize community engagement while strategically deploying social mobilization to maximize both immediate and long-term health gains.

Keywords: Community engagement, Social mobilization, Public health interventions, Sustainability, Nigeria

Introduction

Public health interventions are fundamental to improving population health through disease prevention, health promotion, and the reduction of health inequalities. Globally, governments and international health organizations invest heavily in programs aimed at addressing communicable and non-communicable diseases, improving maternal and child health, and strengthening health systems. Growing evidence indicates, however, that the success of these interventions depends not only on technical design or resource availability but on the

extent to which communities are meaningfully involved in their planning, implementation, and sustainability (WHO, 2020; Abramowitz and Bedson, 2022).

Community engagement has emerged as a key strategy for ensuring that public health interventions are responsive to local needs, culturally appropriate, and socially acceptable. It involves the active participation of community members in identifying health problems, setting priorities, making decisions, and implementing solutions (WHO, 2020). Systematic reviews consistently demonstrate that interventions grounded in meaningful community engagement build trust, enhance program ownership, and produce long-term behavioral change (O'Mara-Eves et al., 2015). Despite its advantages, community engagement can be resource-intensive and, when poorly implemented, may result in tokenistic participation that undermines intended outcomes (Fursova et al., 2023).

Social mobilization, by contrast, represents a more action-oriented and often time-bound strategy that focuses on organizing individuals, groups, and institutions to raise awareness and stimulate collective action towards specific health goals. It frequently employs mass communication, community leaders, and social networks to promote rapid participation in targeted health activities (Jalloh et al., 2020). Although widely and effectively applied in large-scale public health campaigns, including immunization drives, disease outbreak responses, and maternal and child health programs, concerns persist regarding the sustainability of outcomes once external support diminishes (Jalloh et al., 2020).

Within the Nigerian context, persistent public health challenges, including low immunization coverage, poor sanitation practices, inadequate utilization of primary health care services, and regional disparities in health outcomes continue to undermine national health goals (WHO, 2020). Many programs experience limited community participation, weak ownership, and sustainability challenges (Obi et al., 2024). Nigeria's diverse socio-cultural and geographic contexts further complicate the application of uniform public health strategies, underscoring the need for context-sensitive and participatory approaches.

Despite the widespread application of both strategies, limited empirical evidence directly compares their effectiveness, sustainability, and contextual suitability within the Nigerian public health system; existing studies tend to examine community engagement or social mobilization separately rather than as a direct comparison. This study addresses this gap by exploring and comparing community engagement and social mobilization from the perspectives of public health practitioners in Minna, Niger State. To our knowledge, this is among the first qualitative studies to directly compare practitioners' perceptions of both strategies within a single Nigerian public health system, with the aim of generating evidence to inform the design and implementation of more effective and sustainable public health interventions.

Methods

Study Design

This study adopted a descriptive qualitative research design and addressed three research questions: how practitioners perceive the effectiveness of community engagement; how social mobilization influences awareness and participation; and how the two strategies compare in terms of sustainability and long-term impact. A qualitative approach was considered appropriate because it allows for in-depth exploration of participants' experiences, perceptions, and interpretations of community engagement and social mobilization in public health interventions (Creswell and Poth, 2018). The descriptive qualitative approach was selected because it enables the researcher to describe participants' perspectives systematically without imposing predetermined theoretical categories (Sandelowski, 2000). It is particularly suitable for examining how practitioners understand and apply participatory public health strategies in real-world settings.

Study Setting

This study was conducted in Minna, the capital city of Niger State, located in the North-Central geopolitical zone of Nigeria. Minna serves as the administrative and commercial hub of the state and has a diverse population comprising different ethnic, religious, and socio-economic groups. The city has several public health institutions including primary health care centers, government health agencies, and non-governmental organizations involved in public health programmes. Minna was selected because of its accessibility and the presence of practitioners with relevant experience across state, development partner, and local government contexts.

Study Population and Sampling

The study population comprised public health practitioners involved in the planning, implementation, or evaluation of public health interventions within Minna, Niger State. A total of 21 key informants were selected using a purposive sampling technique, a non-probability method in which participants are deliberately selected

based on their specific characteristics, knowledge, or experience relevant to the research questions (Patton, 2015). Participants were selected from across three institutional levels: state government agencies, development partner organizations, and local government authority health departments. The sample size of 21 participants is consistent with established norms for qualitative key informant interview studies, where 15 to 30 participants are generally appropriate for achieving data saturation (Hennink, Kaiser and Marconi, 2017). Data collection continued until thematic saturation was achieved; saturation was assessed iteratively and judged as the point at which subsequent interviews ceased to yield substantially new codes or categories relevant to the research questions, consistent with the approach described by Guest, Bunce and Johnson (2006).

Table 1: Participant Characteristics

Participant ID	Designation / Role	Category	Years of Experience	Sector
KI1	State Immunization Officer	State Staff	10 years	Government
KI2	Deputy Director Nutrition	State Staff	20 years	Government
KI3	Director Public Health	State Staff	15 years	Government
KI4	DHPRS	State Staff	20 years	Government
KI5	Community Engagement Focal Person	State Staff	25 years	Government
KI6	Director Community & Family Health Services	State Staff	10 years	Government
KI7	DPRS	State Staff	16 years	Government
KI8	Reproductive Health Coordinator	State Staff	10 years	Government
KI9	Social Mobilization Officer	State Staff	13 years	Government
KI10	State M&E Officer	State Staff	20 years	Government
KI11	Health Education Officer	State Staff	17 years	Government
KI12	Program Officer	Development Partner	15 years	NGO/Partner
KI13	Program Director	Development Partner	17 years	NGO/Partner
KI14	M&E Manager	Development Partner	20 years	NGO/Partner
KI15	Health Financing Program Officer	Development Partner	15 years	NGO/Partner
KI16	Team Lead	Development Partner	13 years	NGO/Partner
KI17	Public Health Officer	Development Partner	6 years	NGO/Partner
KI18	Program Officer	Development Partner	3 years	NGO/Partner
KI19	State Facilitator (Social & Behavioral Change)	Development Partner	17 years	NGO/Partner
KI20	Director Primary Health Care	LGA Staff	25 years	LGA
KI21	Health Education & Health Promotion Officer	LGA Staff	29 years	LGA

Data collection

Data were collected through face-to-face semi-structured key informant interviews conducted at locations and times convenient for participants. The semi-structured format allowed the researcher to ask follow-up probing questions where necessary to clarify or expand on participants' responses (Kvale and Brinkmann, 2015). The KII guide was structured around the three research questions and consisted of open-ended questions designed to elicit detailed information on participants' experiences of community engagement and social mobilization, their perceptions of the effectiveness and sustainability of each strategy, and the challenges encountered in practice. With participants' permission, interviews were audio-recorded and field notes were taken during and immediately after each interview to capture non-verbal cues and contextual observations. Each interview lasted between 30 and 45 minutes.

Researcher Characteristics and Reflexivity

The lead researcher was a final-year undergraduate public health student conducting this study as part of an academic dissertation, with no prior professional or clinical relationship with any participant and no formal role within the institutions studied. This position was disclosed to participants before each interview. The same researcher conducted all interviews using a consistent guide to minimize variation. Given her background as a public health trainee with an interest in participatory approaches, these potential influences were acknowledged, and coding was guided by participants' accounts rather than prior expectations.

Data Analysis

All recordings were transcribed verbatim. Analysis in NVivo 16 followed Braun and Clarke's (2006) six phases (familiarization, initial coding, searching for themes, reviewing themes, defining and naming themes, and

producing the report), generating 40 initial codes, grouped into 12 categories (e.g., community participation, stakeholder involvement, gatekeepers, and shared decision-making under Community Involvement Processes), and organized into six broader themes. Distinctiveness between categories and themes was established by comparing each candidate grouping against the coded extracts and wider dataset, retaining a grouping only where it captured a coherent, non-overlapping aspect of participants' accounts; overlapping candidates were merged or reworded accordingly.

Table 2: Summary of Thematic Analysis from KII Data

S/N	Initial Codes	Category	Initial Themes	Final Themes
1	Community Participation	Community involvement processes	Community Engagement processes and participation	Theme 1: Nature and process of community Engagement
2	Stakeholder involvement			
3	Community gatekeepers			
4	Shared decision-making			
5	Engagement seen as necessary	Perceived necessity of engagement	Importance of engagement in public health	Theme 2: perceived importance of community engagement
6	Need for continuous engagement			
7	Intervention success linked to engagement	Community engagement outcomes	Perceived outcomes of engagement	Theme 3: Effectiveness and outcomes of community engagement
8	Improved service uptake			
9	Reduced non-compliance			
10	Community acceptance of intervention	Social acceptance and trust		
11	Trust building			
12	Shared understanding			
13	Capacity building through engagement	Community empowerment and capacity	Community capacity building and ownership	Theme 4: Empowerment and ownership through engagement
14	Problem solving			
15	Community ownership	Community ownership		
16	Strong ownership in community engagement			
17	Awareness creation	Awareness and information dissemination	Social mobilization for awareness and participation	Theme 5: Role of social mobilization in awareness and participation
18	Addressing misconceptions			
19	Local communication channels	Communication strategies and channels		
20	Outreach activities			
21	Community dialogue platforms and forums			
22	Peer influence	Participation dynamics in social mobilization		
23	Participation due to incentives in SM			
24	Limited participation in SM			
25	Social mobilization for rapid awareness			
26	SM for wide coverage			
27	Limited feedback			
28	Sustainability through ownership	Sustainability and long-term impact	Sustainability and effectiveness between CE and SM	Theme 6: Sustainability and comparative effectiveness of CE and SM
29	Long-term behavior changes through engagement			
30	Strong sustainability in CE			
31	Weak sustainability in SM			
32	Short-term impact of SM			
33	Weak ownership in SM,	Ownership and participation differences		
34	Strong ownership in CE			
35	Higher participation in CE			
36	Funding problem	Implementation and system-level factors		
37	Cultural barrier			
38	Language barrier			
39	Monitoring and follow-up			
40	Integration of strategies			

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Trustworthiness

Trustworthiness was addressed using Lincoln and Guba's (1985) criteria for qualitative rigor. Credibility was strengthened through peer review of the interview guide by the project supervisors prior to data collection, prolonged engagement with participants during interviews, and verbatim transcription; a subset of participants also reviewed their own transcripts to confirm accuracy (member checking). Coding was undertaken by a single researcher, consistent with common practice in small-scale qualitative dissertations; to mitigate this limitation, provisional codes, categories, and themes were discussed and peer-debriefed with the project supervisors at each analytic phase, and any disagreements were resolved by returning to the coded data extracts. Confirmability was supported through the use of direct participant quotations to substantiate findings. Dependability was enhanced through the maintenance of an audit trail documenting interview dates, and coding decisions.

Results

Participant Characteristics

A total of 21 public health practitioners participated in this study drawn from three institutional categories: state government staff (KI1–KI11), development partner organizations (KI12–KI19), and local government authority staff (KI20–KI21). Their designation ranged from directors and program officers to M&E managers, health education officers, and social mobilization officers. Years of experience ranged from 3 to 29 years, with the majority reporting more than ten years of public health practice. Table 1 presents the characteristics of all participants.

Thematic Framework

Thematic analysis of the 21 key informant interviews generated 40 initial codes, which were grouped into 12 categories and refined into six final themes. Table 2 presents the full thematic framework of the findings.

Theme 1: Nature and Process of Community Engagement

Practitioners described community engagement as a deliberate, structured, multi-dimensional participatory process built on four interconnected elements: community participation, stakeholder involvement, gatekeeper engagement, and shared decision-making. It was characterized not merely as a program activity but as a relational process that determines how communities receive and respond to health interventions.

Participants consistently described community participation as the core of CE, through which communities move from passive recipients to active partners. A Director of Health Planning Research and Statistics noted:

> *"Once you engage with them, you develop the solutions together. Bringing people together, encouraging them to take action — that is what community engagement means." (KI4)*

The engagement of traditional rulers, religious leaders, and ward development committees was identified as particularly decisive in the northern Nigerian context. A Director of Community and Family Health Services observed:

> *"People that have a say in the community, like religious leaders and also community leaders — when they speak, the community listens." (KI6)*

Shared decision-making was described as the feature that distinguishes genuine engagement from superficial consultation, directly linking community involvement in planning to the sense of ownership that sustains program participation over time.

Theme 2: Perceived Importance of Community Engagement

Community engagement was unanimously regarded as the backbone of primary health care delivery. Every participant, regardless of institutional category or years of experience, described CE as indispensable to program success. A Health Education and Health Promotion Officer stated:

> *"Community engagement is the backbone of primary healthcare activity. If you don't engage the community people, you are bound to fail. We cannot do anything without engaging the community." (KI21)*

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A DPRS further characterized interventions implemented without community involvement as structurally hollow:

> *"Without involving the community or engaging with the community, then you will actually be just window dressing." (KI7)*

Participants also stressed that engagement must be continuous throughout the program lifecycle rather than confined to initial phases, as the trust and ownership it builds require active maintenance to be sustained.

Table 3: Practitioners' Comparative Perceptions of Community Engagement and Social Mobilization

Dimension	Community Engagement	Social Mobilization
Nature of participation	Active, dialogic; communities help set priorities and make decisions	Largely one-directional; communities receive and respond to messages
Primary mechanism	Trust-building through gatekeepers and shared decision-making	Awareness creation through mass and interpersonal communication channels
Motivation for participation	Intrinsic, linked to a sense of shared ownership	Often incentive-dependent (tokens, refreshments)
Typical timeframe	Continuous, embedded across the program lifecycle	Campaign-bound, time-limited
Perceived sustainability	High; outcomes described as persisting after formal support ends	Lower; outcomes described as fading once activities or funding stop
Perceived strength	Building durable ownership and behavior change	Rapidly reaching large or dispersed audiences
Practitioner-described relationship	Complementary to SM; the two were consistently described as working together rather than in competition	

Theme 3: Effectiveness and Outcomes of Community Engagement

Participants attributed a range of positive outcomes to community engagement, including improved service uptake, enhanced community acceptance, strengthened trust, and reduced non-compliance. A State Facilitator for Social and Behavioral Change explained:

> *"To build the trust of the communities — that is a core purpose of community engagement. If you didn't involve the community, you will not have positive results." (KI19)*

Trust emerged as the most critical relational outcome, directly determining whether communities accept or resist health interventions. These findings represent practitioners' attributions based on field experience rather than independently measured outcomes; however, their consistency across all three institutional categories lends them considerable analytical weight.

Theme 4: Empowerment and Ownership through Community Engagement

Community engagement was perceived by practitioners to be associated with empowerment outcomes that extend beyond program delivery. Practitioners described communities as developing the capacity to train others, solve health problems collectively, and sustain health activities with less external input. Community ownership was identified by participants as a key indicator of effective engagement. A Program Officer described observable expressions of this ownership:

> *"Youth are carrying sand and cement to support health programs. Women were fetching water themselves after the community were engaged. The community take it into heart, because they believe this is their own, this is part of them." (KI12)*

A Team Lead described communities mobilizing themselves to construct health facilities and provide for health workers, examples that demonstrate ownership not as a sentiment but as a behavioral disposition associated with voluntary, sustained community action.

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Theme 5: Role of Social Mobilization in Awareness and Participation

Social mobilization was described as a distinct strategy characterized by rapid, wide-reaching awareness generation. Its primary function was identified as the creation of initial knowledge conditions that make community engagement and health service uptake possible. SM worked most effectively through culturally appropriate communication channels, town announcers, local drama groups, radio programs, and community dialogue that penetrate social spaces and reach audiences that formal health communication channels often miss. However, a critical structural limitation was identified. Participation in social mobilization activities was largely incentive-dependent rather than intrinsically motivated. A State Health Education Officer noted:

> *"Social mobilization needs token or refreshment. Without refreshment, participation is low. Once incentives stop, participation reduces." (KI11)*

Similar patterns were reported by practitioners in other institutional categories. A Development Partner Health Financing Program Officer explained:

> *"People participate because of incentives such as soap, money, gifts. When incentives stop, participation drops." (KI15)*

A State DPRS made a related observation:

> *"In social mobilization, people sometimes expect incentives before participating." (KI7)*

The predominantly one-directional communication model of SM was also identified as a limitation, as it positions communities as targets rather than participants in dialogue, limiting the development of the ownership and agency associated with sustained behavior change.

Theme 6: Sustainability and Comparative Effectiveness of CE and SM

This theme addresses the central research question of the study. Practitioners consistently perceived community engagement as significantly more sustainable than social mobilization. A State Immunization Officer stated:

> *"Community engagement is more sustainable than social mobilization because there is a strong ownership. If you want something more sustainable, you go for community engagement." (KI1)*

Community ownership was identified as the primary mechanism through which CE achieves superior sustainability, the point at which communities internalize a program as their own and voluntarily sustain it beyond the formal program period. Social mobilization by contrast was repeatedly associated with temporary, campaign-bound outcomes. A Local Government Authority Director of Primary Health Care observed:

> *"Social mobilization is only done during campaign and end after the campaign; campaign-based approach leads to temporary impact." (KI20)*

A Development Partner Public Health Officer made a similar point:

> *"Social mobilization gives an overview but it doesn't last long." (KI17)*

No participant expressed a view privileging social mobilization over community engagement for long-term sustainability. This consistency across all three institutional categories may reflect a genuine, shared professional consensus grounded in practitioners' direct field experience; it may equally reflect the purposive sampling strategy, which selected practitioners already engaged in participatory public health work and may therefore under-represent perspectives more favorable to campaign-based approaches. Importantly, practitioners did not view the two strategies as competing. They were consistently described as complementary. A Program Director articulated this functional relationship:

> *"Social mobilization works alongside community engagement. They work hand in hand. One cannot work without the other. Community engagement sustains social mobilization — they are the foundation; they are the foot soldiers." (KI13)*

Common implementation challenges identified included funding constraints, cultural and language barriers, and weak monitoring and follow-up systems; all of which affect both strategies and undermine program sustainability when inadequately addressed. Table 3 summarizes practitioners' comparative perceptions of the two strategies across the dimensions raised most consistently in the interviews.

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Discussion

This study explored community engagement and social mobilization as strategies for effective public health interventions from the perspectives of 21 practitioners in Minna, Niger State. The findings provide practitioner-grounded evidence that both strategies are perceived to contribute meaningfully to public health but in fundamentally different ways and with different implications for sustainability.

Community Engagement as a Participatory and Empowering Process

The finding that CE is understood as a structured, multi-dimensional participatory process is consistent with WHO (2020). The particular emphasis on community gatekeepers reflects the socio-cultural dynamics of northern Nigeria, where traditional authority structures significantly shape community responses to health programs (Bassey and Omoregie, 2024; Obi et al., 2024; Ogah et al., 2024). This aligns with evidence that community-led collaborations through trusted local structures improve service utilization and acceptability in Nigeria (Akinyemi et al., 2021). From the Social Ecological Model perspective, CE operates primarily at the interpersonal and community levels, activating social networks, cultural norms, and collective efficacy critical for intervention acceptance and behavior change (Golden and Earp, 2012). The emphasis on shared decision-making aligns with Empowerment Theory, which holds that meaningful empowerment requires the redistribution of decision-making power between health institutions and communities (Perkins and Zimmerman, 1995; Wallerstein et al., 2018). The unanimous view that CE is indispensable is consistent with O'Mara-Eves et al. (2015), and the insistence on continuous engagement reflects what Brunton et al. (2017) identify as the need for sustained institutional commitment.

Social Mobilization: Strength and Structural Limitations

The perceived contribution of SM to rapid, wide-reaching awareness generation is consistent with UNICEF (2018) and evidence from Nigeria's polio eradication initiative (Duru et al., 2019). Mohammed et al. (2024) highlight that communication and local demand generation remain central to immunization uptake in Nigeria, underscoring SM's continued relevance. However, the structural limitations identified, including incentive-dependency and a reliance on repeated, time-bound campaigns to sustain demand, echo concerns raised by Jalloh et al. (2020) regarding social mobilization for immunization in low- and middle-income countries. From an Empowerment Theory perspective, the absence of community involvement in decision-making is fundamentally inconsistent with the conditions required for sustained behavior change (Perkins and Zimmerman, 1995; Wallerstein et al., 2018).

Comparative Sustainability: Community Engagement versus Social Mobilization

The perceived superiority of CE in terms of sustainability is consistent with O'Mara-Eves et al. (2015). The identification of community ownership as the primary sustainability mechanism is consistent with Brunton et al. (2017) and Empowerment Theory. The perception that SM produces temporary results aligns with UNICEF (2018), and the finding that practitioners viewed the two strategies as complementary is likewise consistent with UNICEF's (2018) account of communication for development as one component within a broader, multi-strategy approach. From the Social Ecological Model, this complementarity reflects the different levels each strategy primarily activates, SM operates at the individual and organizational levels through information dissemination, whilst CE strengthens the interpersonal and community levels through trust-building, shared ownership, and collective efficacy (Golden and Earp, 2012). An alternative explanation, however, is that the perceived superiority of CE partly reflects how practitioners are trained and evaluated: because programme guidelines and donor frameworks in Nigeria increasingly frame CE as best practice, practitioners may have learned to describe their work in terms that favor CE regardless of its measured outcomes, a form of social desirability that this study's design cannot rule out. It is also possible that SM appeared less sustainable not because it is inherently inferior but because it was more often described in relation to short, externally funded campaigns, whereas CE was discussed in relation to longer-running, more embedded programmes; the comparison may therefore partly reflect differences in how the two strategies are typically deployed rather than differences in their intrinsic sustainability.

Limitations

This study was conducted solely in Minna, Niger State, with 21 purposively selected participants, which may limit transferability to other Nigerian contexts. The sample was also unevenly distributed across institutional categories (11 state, 8 development partner, 2 local government), so local government perspectives are likely under-represented. The study relied exclusively on practitioners' perspectives, excluding community members'

views, and findings reflect subjective perceptions and professional attributions rather than objective, independently verified outcome measurements.

Conclusion

This study provides practitioner-grounded evidence that CE and SM are perceived as complementary rather than competing: CE was linked to the trust, ownership, and collective capacity underpinning sustained community action, while SM was linked to rapid awareness generation and early demand creation. As these findings reflect perceptions rather than measured outcomes, they should be read as practitioner attributions rather than demonstrated effects. Based on these perceptions, three practical steps may be considered: allocating dedicated CE budget lines (e.g., gatekeeper and ward-level dialogue) within existing PHC and immunization programmes rather than treating it as an unfunded add-on; sequencing SM for early awareness while building CE structures, such as community health committees, in parallel for handover; and incorporating ownership- and trust-related indicators, not only coverage figures, into routine monitoring and evaluation. Future research should combine longitudinal, comparative, and mixed-methods studies, incorporating community perspectives and objective outcome measures, to test whether these perceived differences are reflected in measurable programme outcomes.

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Data availability: The datasets generated and analyzed during this study are not publicly available due to participant confidentiality but are available from the corresponding author on reasonable request.

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CRediT role of authors: All authors contributed to this work according to the CRediT (Contributors Roles Taxonomy) system as follows: Conceptualization, L.U. and A.A.; Methodology, L.U and AA.; Formal analysis, L.U.; Investigation, L.U.; Resources, J.I.; Writing – Original Draft Preparation, L.U.; Writing – Review & Editing, A.A., O.T.V., S.B.K. and M.F.T.; Validation, Y.S., H.U-Y. and P.H.A.; Supervision, N.U.A. and A.A. All authors have read and agreed to the published version of the manuscript.

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References

Abramowitz, S. and Bedson, J. (2022) 'Community engagement in disease outbreak preparedness and response', in Manoncourt, E., Obregon, R. and Chitnis, K. (eds.) Communication and community engagement in disease outbreaks. Springer, pp. 43–72.

Akinyemi, O.O., Adebayo, A., Bassey, C. et al. (2021) 'Assessing community engagement in Nigeria polio eradication initiative', BMJ Open, 11(8), e048694.

Bassey, I.E. and Omoregie, E.F. (2024) 'Community involvement: a tool for successful implementation of primary health care services', Direct Research Journal of Public Health and Environmental Technology, 9(3), pp. 92–105.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', Qualitative Research in Psychology, 3(2), pp. 77–101.

Brunton, G., Thomas, J., O'Mara-Eves, A. et al. (2017) 'Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions', BMC Public Health, 17, 944.
Creswell, J.W. and Poth, C.N. (2018) Qualitative inquiry and research design: choosing among five approaches. 4th edn. SAGE.
Duru, J.I., Usman, S., Adeosun, O. et al. (2019) 'Contributions of volunteer community mobilizers to polio eradication in Nigeria', American Journal of Tropical Medicine and Hygiene, 101(4 Suppl), pp. 74–84.
Fursova, J., Bishop-Earle, D., Hamilton, K. et al. (2023) 'An intersectional feminist analysis of community participation', Community Development Journal, 58(3), pp. 453–471.
Golden, S.D. and Earp, J.A.L. (2012) 'Social ecological approaches to individuals and their contexts', Health Education & Behavior, 39(4), pp. 364–372.
Guest, G., Bunce, A. and Johnson, L. (2006) 'How many interviews are enough? An experiment with data saturation and variability', Field Methods, 18(1), pp. 59–82.
Hennink, M.M., Kaiser, B.N. and Marconi, V.C. (2017) 'Code saturation versus meaning saturation: how many interviews are enough?', Qualitative Health Research, 27(4), pp. 591–608.
Jalloh, M.F., Wilhelm, E., Abad, N. and Prybylski, D. (2020) 'Mobilize to vaccinate: lessons learned from social mobilization for immunization in low- and middle-income countries', Human Vaccines & Immunotherapeutics, 16(5), pp. 1208–1214.
Kvale, S. and Brinkmann, S. (2015) InterViews: learning the craft of qualitative research interviewing. 3rd edn. SAGE.
Lincoln, Y.S. and Guba, E.G. (1985) Naturalistic inquiry. SAGE.
Mohammed, Y., Reynolds, H.W., Waziri, H. et al. (2024) 'Exploring the landscape of routine immunization in Nigeria: a scoping review', Vaccine X, 20, 100563.
O'Mara-Eves, A., Brunton, G., Oliver, S. et al. (2015) 'The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis', BMC Public Health, 15, 129.
Obi, C., Ojiakor, I., Etiaba, E. and Onwujekwe, O. (2024) 'Collaborations and networks within communities for improved utilization of primary healthcare centers', International Journal of Public Health, 69, 1606810.
Ogah, P.O., Uguru, N., Okeke, C. et al. (2024) 'Primary health care in Nigeria: best practices and quality of care', BMC Health Services Research, 24, 963.
Patton, M.Q. (2015) Qualitative research and evaluation methods. 4th edn. SAGE.
Perkins, D.D. and Zimmerman, M.A. (1995) 'Empowerment theory, research, and application', American Journal of Community Psychology, 23(5), pp. 569–579.
Sandelowski, M. (2000) 'Whatever happened to qualitative description?', Research in Nursing & Health, 23(4), pp. 334–340.
United Nations Children's Fund (2018) UNICEF 2017 report on communication for development. UNICEF.
Wallerstein, N., Duran, B., Oetzel, J.G. and Minkler, M. (eds.) (2018) Community-based participatory research for health. 3rd edn. Jossey-Bass.
World Health Organization (2020) Community engagement: a health promotion guide for universal health coverage in the hands of the people. WHO.

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