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ABSTRACT

The Alma Ata declaration puts responsibilities on the community as an important stakeholder, including making decisions on planning, organizing, and implementation of health services at primary level. The University of Medical Sciences Ondo (UNIMED) operates a unique and innovative model of Primary Health Care to deliver "Health For All". The objective of this research was to assess the relationship between stakeholders' engagement and community involvement and utilization of maternal and child health services in selected communities of Ondo State in Southwestern Nigeria. The UNIMED model involved a top-bottom approach to community participation and engagement that dovetailed to the selection of 3 local governments, communities and comprehensive health centers. Oke-Igbo community was the target population. The study area is a homogenous community in ward 7 of Ile – Oluji/Oke-Igbo Local government area (LGA), the pattern of chronic diseases seen in the register, with the At-Risk document registering hypertension, diabetes, sickle cell anemia and arthritis and related joint conditions. One year before the intervention, a total of 256 pregnant women attended antenatal care (ANC). This increased to 795 pregnant women attending ANC within a one-year period of implementing community mobilization, giving an increment of 3.1-fold. A marginal increment of 13% was reported in baby deliveries when the data for one year before and after the project was compared. Similarly, one year before the intervention, a total of 744 children got up to Penta 3 vaccine in the community PHC. This increased to 822 children getting up to Penta 3 vaccine within a one-year period of implementing community mobilization, giving another marginal increment of 10.5%. It was concluded that this model that has been worked on should be scaled up to the other communities in the state to improve health outcomes in the State.

Keywords: Community engagement, Primary Health Care, Maternal and child health, Health service utilization, UNIMED care models

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INTRODUCTION

The Alma Ata declaration on Primary Health Care (PHC), regarded as a core strategy to achieving Health For All (HFA), has community participation as one of her principles [1]. Community participation puts people in a position to participate in solving their own health problems, taking appreciable responsibilities including mobilizing local resources and creating demands for health care services at the community level. The community is responsible for planning, organizing, operation and control of primary health care [1] and a participatory approach to health care governance would assist in achieving universal health coverage [2]. Community participation empowers society and guarantees more commitment from stakeholders. The importance of community participation in primary health care has been documented [3, 4].

There are several levels of community participation, ranging from informing to manipulation, therapy of the community to partnership and citizen control. Ideas are usually brought about by any of the stakeholders, but the ability of communities to be carried along determines the success or otherwise of intervention programmes. Traditionally these have roles to play in mobilizing the communities in efforts that will benefit the communities at the primary health care level.

Several challenges face a successful implementation of Primary health care level system in Nigeria, including its local actors such as the ward and health facility development committees. Several challenges are bound to characterize efforts at community participation in health programmes [5,6], ranging from illiteracy, resistance to change, politics, migration, poor political support, to poor planning and implementation by the health care system authorities.

One of the indicators of the success of HFA through community participation at the PHC level is that of maternal health services, most especially access to ANC and health facility delivery. These indicators may improve when barriers toward establishing health as a shared responsibility among the population are removed and careful programme planning and implementation by the health workers in the presence of Government support is ensured.

Authors observed that universities in Nigeria have piloted various schemes of community health programme, but most are not sustainable and could not guarantee HFA due to poor community participation. Most PHC seems to have weak community-based structure, top-bottom management, with mere tokenisms in community engagement and involvement. There has been no previous record of attainment of a PHC with its HFA services in any setting in Nigeria. Hence the conceptualization of the UNIMED/UNIMEDTH-assisted PHC-HFA

model. There are five models being planned and these are (1) the full professional community medical and health services, in 3 political *wards (sites), (2) c*ommunity health/PHC services as may best be provided within the given state or region that our department (CM) is physically present in - *(e.g. Epe site, (3) c*ommunity medical assistance and partnership for entire political ward or LGA in which our department has no physical presence e.g. a political ward in Ose LGA, (4) other consultant community medical and health assistances and collaborations to political wards, LGAs, states or beyond outside Ondo State and (5) community medical assistance and partnership for non-statutory community, not a whole (legally existing) country, state/region/province, LGA or political ward as already designated by the govt or country's constitution as a health service unit of any sort, officially

In Nigeria, most PHC have weak community-based structure, top-bottom management, with mere tokenisms in community engagement and involvement. There has been no previous record of attainment of a PHC with its HFA services in any setting in Nigeria. Hence the conceptualization of the UNIMED/UNIMEDTH-assisted PHC-HFA model. There are five models being planned and these are (1) the full professional community medical and health services, in 3 political wards (sites), (2) community health/PHC services as may best be provided within the given state or region that our department (CM) is physically present in - (e.g. Epe site, (3) community medical assistance and partnership for entire political ward or LGA in which our department has no physical presence e.g. a political ward in Ose LGA, (4) other consultant community medical and health assistances and collaborations to political wards, LGAs, states or beyond outside Ondo State.

Only the first model is examined in this paper. The conceptual framework for this model includes the implementation activities for this first model in the ward 7 of Oke-Igbo/Ile Oluji LGA being described include appropriate community entry and documented agreement to engage in the programme. The objective of this research was to assess the relationship between stakeholders' engagement and community involvement and utilization of maternal and child health services in selected communities of Ondo State in Southwestern Nigeria

METHODOLOGY

The study area was Ondo State in Southwestern Nigeria, with a population of about 4 million. The University of Medical Sciences (UNIMED) in Ondo town is the first specialized medical University in Nigeria, with a view to providing comprehensive medical education to the citizenry. The University launched an innovative model of Primary Health Care model to deliver

"Health For All" through a community-based approach. The programme was planned to take place in 3 locations in the State, namely an urban, semi-urban and a rural area.

Study design: Descriptive cross sectional
Target population: The stakeholders in the PHC model including Governments, the leadership of the Ministry of Health, Primary Health Care Board, the Hospital Management Board, the Medical Officers of Health (MoHs) and Chairman of the 3 Local Government Areas (where the communities are located), UNIMED academic staff of the Department of Community Medicine, the health care workers in the PHC and members of the selected communities.

Target population: The unit of enquiry was the respective health centers workforce and the communities. Private hospital care workers were excluded.

Sampling methods: This happened through stakeholders' engagement. The criteria were that the PHC to be selected must be able to provide comprehensive and integrated secondary care health services which include preventive, promotive and curative services. Maroko Comprehensive Health Center (CHC) in Ward 1 of Ondo West LGA was selected as the urban area, Oke-Igbo CHC in Ward 8 of Oke-Igbo community in Ile-Oluji/Oke-Igbo LJA was selected as semi-urban while Ilutuntun CHC in Okitipupa LGA was selected as the rural area.

Stakeholder engagement: This was a top-bottom approach to community participation. The processes in the implementation of the first model mentioned above are

- Stakeholders meeting at the ministry of health before the model takes off, to decide on the choice of Senatorial district to locate the 3 PHCs and the LGAs. After exhaustive deliberations, 6 LGAs spanning the 3 senatorial districts were selected using the sampling criteria above.
- Visiting the 6 PHCs and selecting only 3 based on the stated criteria.
- Meeting with the MoHs of the 3 selected PHCs to determine the criteria for ward selection and community engagement.
- Community entry and community gate keepers' engagement. Ward and health facility health committees were sensitized. Community engagement took place thrice in each community until an appreciable community acceptability was achieved.
- Dejure census and PHC numbering of houses in the selected wards was carried out. When the National population in Oke-Igbo and Ilutuntun communities could not give us the population figures as baseline, the community funded the dejure census with minimal financial involvement

controlled by them, and huge community volunteering.

- GIS Mapping of the household in the entire community including administration of a baseline health assessment questionnaire.
- Employment of a community-based nurse midwives volunteered by each community for each community (by the University).
- Conduct of community rounds by the nurse which also includes visit to the identified. The University Clinicians in the Department of Community Medicine provided backing for the nurse via telemedicine.
- Validation of the health status of the community by opening "At Risk" registers and consultations by doctors from the University. Chronic diseases were identified, mapped and assessed.
- Establishment of the birth, death, marriage and divorce registers and the establishment of the rest of the work of the community nurse-midwife
- The nurse provided collaborative services with health care workers in the Primary Health Centres and 2 community volunteers, including referral of clients from communities to health facilities, provision of community-based health services, schools and market visitation and mobilization for improved health care.

Research instruments employed in this model were the designed health assessment questionnaire, the At-Risk Register and the validation questionnaire for chronic diseases in addition to accessing baseline data on service utilization in the health facility. All design instruments were validated by a team of experts raised by the State Primary health care board

Data analysis: Community health problems identified during baseline health assessment and validation of At-Risk Registers were compared with one year health service utilization data, and these were presented in Tables and charts.

RESULTS

Figure 1 shows the enumeration area map of Ward 7 in Ile-oluji/Oke-igbo LGA of Ondo State. The list of activities carried out under the model being described was undertaken in these areas. Table 1 shows some community members listed while placing the At-Risk-Registers. About 1106(45.4% of them were male while the rest are females. A total of 91(3.7%) of them are under 5 in age while 433(17.8%) of them were never married, 528 (21.7%) of them were up to primary school level of education. Table 2 shows the pattern of chronic diseases seen in the register, these include hypertension, diabetes,

sickle cell anemia and arthritis and related joint conditions.

Figure 2 shows a chart depicting the reproductive Service Utilization one year before and after community mobilization. One year before the intervention, a total of 256 pregnant women attended antenatal care. This increased to 795 pregnant women attending ANC within a one-year period of implementing community mobilization, giving an increment of 3.1-fold.

One year before the intervention, a total of 123 pregnant women delivered in the community PHC. This increased to 139 pregnant women delivering within a one-year period of implementing community mobilization, giving a marginal increment of 13%.

Similarly, one year before the intervention, a total of 744 children got up to Penta 3 vaccine in the community PHC. This increased to 822 children getting up to Penta 3 vaccine within a one-year period of implementing community mobilization, giving another marginal increment of 10.5%.

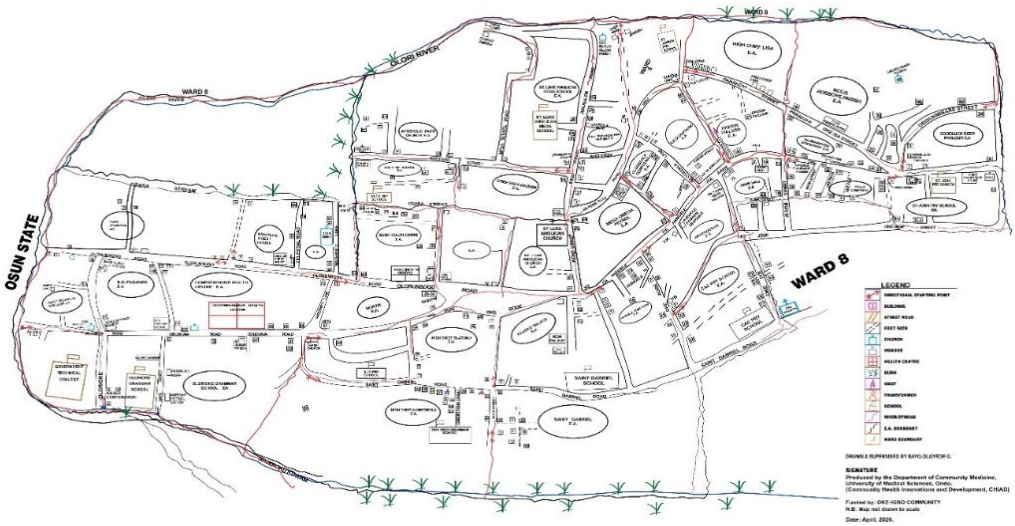

Figure 1: Enumeration Area Map of Ward 7, Ile-oluji / Oke-igbo LGA

Table 1: Socio-demographic Characteristics data of individuals listed (n = 2487)

Variable	Frequency	%
Gender		
Male	1106	45.4
Female	1381	54.6
Age categories		
<1(infants)	16	0.7
Under 5s	91	3.7
15-49(female)	714	28.7
Marital status		
Never married	1433	57.7
Currently married	949	38.1
Others/Not applicable	105	4.2
Highest level of education		
Primary	528	21.7
Secondary	1248	51.2
Tertiary	255	10.5
Others	456	16.6

Table 2: Pattern of Chronic diseases in the At-Risk-Register

Chronic Illness	Agreed periodicity
Hypertension	Twice per annum(minimum)
Diabetes	Twice per annum(minimum)
Arthritis and related conditions	Twice per annum(minimum)
Tuberculosis	Monthly
Sickle cell anaemia	Twice per annum(minimum)
Mental health	Twice per annum (minimum, except called)

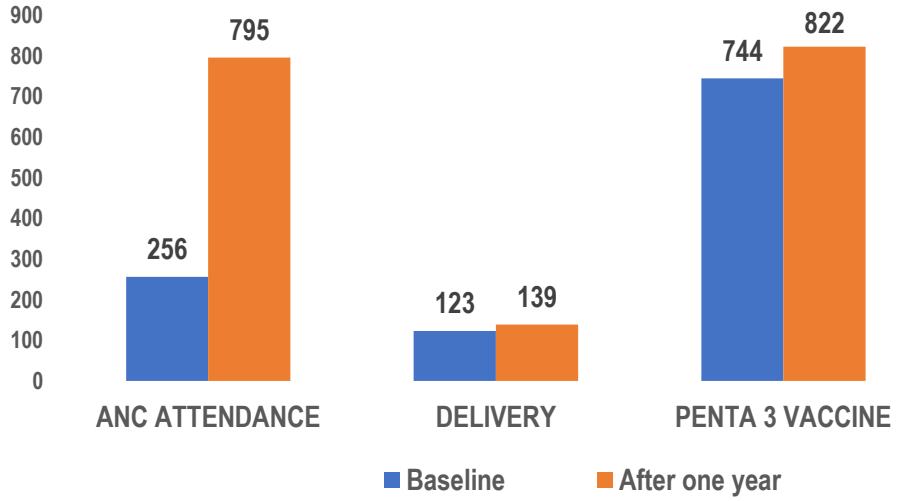

Figure 2: Reproductive Service Utilization one year before and after community mobilization

DISCUSSIONS

The results presented as the preliminary outcome of data generated from only one of the sites show a promising intervention. The role of community mobilization activities thus becomes crucial [1, 7]. Mobilization fosters improved awareness and a possible behavioural change in knowledge and improved access and utilization of health services

In this study, the period one year before and after this innovative community intervention and mobilization approach was compared. There was an appreciable increase in Antenatal attendance after the project following the same pattern of the number of deliveries on comparism. This supports other studies that reported that community participation breeds improved delivery of community-based survival interventions for mother, newborn and children [8. 9. This points to the fact that the degree of community mobilization and participation is a possible measure of ownership and sustainability of programmes.

The community action cycle described led to an appreciable improvement in community awareness, while the rational to use community health resources became more apparent. The entire Ondo State needs to explore the possibilities of incorporating this model of community mobilization in order to improve health outcomes of mother, newborn and children.

In this study, there is a far appreciable increase in the Pentavalent 3 vaccine when compared to the baseline. The role of community mobilization in increasing vaccination uptake has also been reported [10], and in making efforts in solving Community diseases problems [11]. Mothers in ANC or infant welfare clinics have the potential to receive information during mobilization and sensitization that could have led to the observed difference. Along with the line of implementation, researchers observed that communities must be responsive and show interest in programmes that could help them. Oke-Igbo community greatly accepted this idea, and they are already benefitting in the project.

CONCLUSION:

The conceptualization and successful implementation of the UNIMED model of primary health care Health For All concludes that a statutory community-based care is possible in Nigeria with appropriate community engagement and participation. Authors hereby recommend the acceptability of the model of PHC that has the potential of improving health outcomes; it should be allowed and implemented across the various LGAs in the entire Ondo State.

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