BACKGROUND OF THE STUDY

Globally, for more than three decades, many countries of the world under WHO have adopted PHC as the focus of health policy with emphasis on community-based health promotion and disease prevention activities using a multi-disciplinary approach (WHO, 2005). From observation of the target community, there is no indication of past or current health promotion initiatives and deliberate advocacy for the benefit of the residents. These necessitated participatory and community-based health promotion practice to enable them increase control over their health and its determinants. Specific Objectives were: (1). To carry out fact-finding interactions with consumers and providers of healthcare services concerning the provision of community-based health promotion services, (2) Plan for sustained health promotion services with in-built strategies for monitoring performance, (3) Use participatory actions in providing health promotion services, (4) Undertake participatory evaluation of the impact of health promotion services as the cycle continues until the community is sufficiently empowered to function independently.

PHASE III ACTIONS/STRATEGIES

1. Creating supportive environment for health promotion covered: a) Establishment of health committees to strengthen leadership for health promotion, (b) Advocacy visit to: (i) Council Chairman with request for a health centre and a primary school (community was advised to provide land for the projects and this is still in the planning stage), (ii) Ministry of Women Affairs (to aid skills acquisition for women and youth), (iii) sanitation/water/electricity agencies for inter-professional collaboration, (iv) town planner to advise on water drainage, 2) Strengthening community action and (3) Capacity building through (i) community mobilization, education, involvement in health promotion activities and strategies for meeting the needs, setting priorities, planning and implementing actions; and evaluating outcomes with in-built health surveillance to achieve health and well-being at a sustained level. (ii) Under the guidance of the health committees, the youth and sanitation board evacuated refuse to improve drainage in some parts of the community, (iii) Health education is carried out once every month in the designated areas within the community, (iv) training of youths as peer educators to control alcoholism and smoking, (v) Dissemination of available new health information monthly at the market and community hall, (4) Promoting public policies through: (i) control of indiscriminate refuse disposal, (ii) Promoting compulsory ownership of toilet facility in every home, (iii) Declaring every last Saturday of the month for compulsory sanitation.

METHODS

PHASE I: Community emersion was done in October 2014 by the researchers to get familiar with the research setting. This is a sub-urban community in South-East Nigeria. Ethical approval/Consent was obtained from the community leaders and the research participants who were assured of confidentiality at all times. Participation was voluntary. Population involved 18 members of action research group (opinion leaders) selected through Purposive sampling and 27 other community members as research participants selected through Snowball sampling. Awareness Training was offered to Action Research Group Members to enable them function effectively. Participatory Fact-Finding of Health Promotion Needs Involved: (1) Two Focus group discussions, (2) In-depth interviews, and (3) Participant observation. Data Analysis was done thematically. The following themes emerged: Poor water drainage, improper waste disposal, need for health promotion information, youth involvement in alcoholism and smoking, poor formal education status of youths, non functioning power supply; lack of health center and knowledge of existing health policies for the benefit of the community.

PHASE II: Participatory planning of actions with in-built strategies for sustainability. Team meetings: Findings from data were critically reflected upon by the action research group during research committee meetings.

PHASE IV EVALUATION OF ACTIONS AND OUTCOMES

Formative evaluation was undertaken in February 2015: (i) There was progress with ongoing implementation of actions, (2) noticeable improvement in the following areas: (i) sanitary condition of most areas of the community where commercial waste containers were located at strategic points and (ii) Improved drainage in some parts of the community. Actions are ongoing and the next evaluation is in February 2016. The project should be completed in November 2016 when members of the committee would have been empowered through more educational interventions to gain enough knowledge and skills to carry on with their health promotion activities.

CONCLUSION: The process fostered inter-professional collaboration among healthcare and social services providers and should increasingly empower members of the community to take control over their health and its determinants to improve their health. The implication of the findings of this action research is that community-based health promotion practices should receive attention globally to enhance transformative community health nursing practice.


ACTION RESEARCH ON HEALTH PROVIDERS AND CONSUMERS’ COLLABORATIVE INITIATIVES FOR PROVISION OF COMMUNITY-BASED HEALTH PROMOTION SERVICES IN A SUB-URBAN COMMUNITY OF SOUTH-EAST NIGERIA

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