

## Original Research Article

# A Qualitative Exploration on Knowledge of Community-Integrated Management of Childhood Illnesses among Community Resource Persons and Primary Health Care Workers in Oyo State, Nigeria

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**Abstract:** Community-Integrated Management of Childhood Illnesses (C-IMCI) is a multipronged strategy developed by the World Health Organization aimed at reducing childhood mortality and morbidity through the integration of enhanced health care services, improved case management skills and healthier community practices. Community resource persons (CORPs) play an important role in the knowledge transfer of this strategy to mothers of U-5 children within their communities. This study explored the knowledge of C-IMCI among CORPs and other primary healthcare workers, as well as accessibility to training, and recommendations for the promotion of C-IMCI. Qualitative data were obtained from a larger cross-sectional study conducted in Ibadan North East and Akinyele Local Government Areas of Oyo State, Nigeria. Data were collected through Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) among community resource persons, community health workers and selected key health officers in two local government areas (LGAs) in Oyo State, Nigeria. Data were transcribed and analyzed thematically. There was poor knowledge of C-IMCI among the participants, the majority of respondents received C-IMCI-related information from nurses and LGA staff. Regarding training, a few respondents who received the initial training on C-IMCI had been transferred from their LGAs, monitoring was infrequent and implementation of C-IMCI was not effective in the sampled areas. Community Resource Persons and Primary Health Care workers in this study did not receive regular trainings on C-IMCI; hence their knowledge was limited in this regard. Increased access to trainings on community practices would help in bridging the existing knowledge gaps in this field.

**Keywords:** Community-Integrated Management of Childhood Illnesses, Community health workers, Community resource persons, Implementation, Knowledge.

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## INTRODUCTION

In spite of impressive decline in childhood mortality between the year 1990 and 2015, the Millennium Development Goal 4 (MDG) of attaining two-thirds reduction of under-5 mortality rate (U5MR) by 2015 was not achieved (You *et al.*, 2015; Liu *et al.*, 2016). Observing current global, regional, and local trends of child morbidity and mortality rates (Yaya *et al.*, 2017; Hug *et al.*, 2019; Adedokun and Yaya, 2020; World Health Organization, 2022) and with less than a decade in our hands to the end of the Sustainable Development Goals (SDGs) (World Health

Organization, 2022), achieving the third Sustainable Development Goal in Nigeria the giant of Africa will require the utilization of proven strategies and evidence-based approaches.

In order to improve children's growth and development while reducing their risk of illness and mortality, WHO and UNICEF have collaborated on a project called Integrated Management of Childhood Illnesses (IMCI) (Gera *et al.*, 2016; García Sierra & Ocampo Cañas, 2020). It consists of three elements: enhancing case-management competencies of

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healthcare workers, improving health system support, and bettering household and community practices (C-IMCI), with the later substantially improving the health outcomes of children and requiring the smallest resources for implementation (Mukunya *et al.*, 2014). In 1997, WHO/UNICEF introduced 16 key household practices such as immunization, exclusive breastfeeding, vitamin supplementation, etc. relevant for C-IMCI (Gera *et al.*, 2016). By bringing health interventions closer home, C-IMCI has also resulted in reduced health care costs and improved knowledge and practice among caregivers (Shrivastava, Shrivastava, & Ramasamy, 2013; Nguyen *et al.*, 2013).

Despite the fact that IMCI was initially introduced to Nigeria more than 20 years ago (Ophori *et al.*, 2014), implementation has been quite sub-optimal. A study in Osun State, Nigeria found that the usage of C-IMCI significantly increased the rates of child growth, development, and survival (Ogundele *et al.*, 2016). It is common for families to receive training on key household practices (KHPs) from community resource persons (CORPs) who have themselves received prior training on C-IMCI (Jibo *et al.*, 2014). How much CORPs/community health workers (CHEWs) contribute to health promotion through community mobilization, house-to-house vaccine administration, the dissemination of health information, and the treatment of pediatric disorders has been amply demonstrated elsewhere (Haines *et al.*, 2007; Barnett *et al.*, 2017). These workers bring health interventions closer to the people who need them, especially in low- and middle-income nations like Nigeria where access to primary health care (PHC) is constrained.

We believe that caregivers' uptake of C-IMCI is hinged on the availability of knowledge at their disposal. Consequently, when the CORPs/CHEWs or other health workers are not well-informed in this regard, one can expect that C-IMCI will be suboptimal. With special consideration to our local context where CORPs/CHEWs champion basic health delivery, the aim of this study was to explore the knowledge of C-IMCI among CORPs/CHEWs and other healthcare workers, as well as accessibility to training, and recommendations for promoting C-IMCI.

## METHODOLOGY

### Study Design

This qualitative study utilizing Focus Group Discussions (FGDs), and In-depth Interviews (IDIs) was part of a broader mixed-methods research investigating childhood nutritional status and the implementation of C-IMCI in Ibadan, Nigeria.

### Stud Instrument

A semi structured interview guide consisting of open-ended questions was developed to collect data in line with the study aim.

### Study Area

Akinyele and Ibadan North East local government areas (LGAs), Ibadan, Nigeria.

### Study Population

Participants were Community Resource Persons, community health officers, IMCI officers and select top-tier family health/PHC officers at the Oyo State Ministry of Health.

### Data Collection

Four Focus Group Discussions were conducted, two in each of the LGAs. Each focus group consisted of eight Community Resource Persons, a moderator, a recorder, and an observer. A mix of English and Yoruba language were used in the FGDs. In all, nine in-depth interviews IDIs- 3 with key IMCI state officers and 6 with family health/PHC officers were conducted.

### Data Analysis

Data from the FGDs and IDIs were transcribed, translated to English, and analyzed using the thematic approach to qualitative data analysis by generating themes from recurring opinions of discussants and interviewees.

### Ethical Considerations

Ethical approval for this study was obtained from the Oyo State Ethical Review Board (Ethics Code: AD 13/479/595) Permission was further granted by relevant L.G.A. authorities and health facilities. Respondents were informed of their right to decline or withdraw from the study at any time without any adverse consequence.

## RESULT

### Socio-Demographic Characteristics

A total of 17 health workers; 8 CORPs, 3 key IMCI state officers, and 6 senior PHC workers participated in this study.

### Themes

Results from the FGDs and IDIs were grouped into four main themes: respondents' understanding of C-IMCI; source of information, training, and monitoring of C-IMCI activities; implementation of C-IMCI in Oyo State; and possible reasons for non-adherence to C-IMCI and recommendations for promoting KHPs.

### Respondents' Understanding of C-IMCI

When asked the meaning of C-IMCI, virtually all the respondents in the focus groups (and some in-depth interviewees) did not have an answer, until further explanations were given about individual KHPs. Subsequently, more than half alluded to understanding what C-IMCI entailed, stating that it involves household or community activities that ensure a child is healthy.

*"We do not even understand the meaning of C-IMCI, but we know there are practices a mother can perform in the home before she brings the child to the health facility (FGD 4).*

*"These are practices like immunization, breastfeeding, environmental sanitation, personal hygiene and care of the baby" (FGD1).*

*"Community IMCI is one of the components of IMCI in which the community is carried along on how to take care of children 0-5 years at home and at the community level. It is a strategy that encourages joint efforts aimed at reducing childhood illnesses and mortality" (IDI 1).*

### **Source of Information, Training, and Monitoring of C-IMCI Activities**

It was generally agreed that healthcare workers neither received adequate nor regular training on C-IMCI; as such not many of them are well-equipped to transfer the requisite knowledge to mothers and caregivers.

*"We trained health workers massively on IMCI some years ago across all the 33 Local government Areas in the state, but not on the community component of IMCI" (IDI 1).*

*"We don't usually get trained concerning these things, Government should help us by sending us for trainings in the area of C-IMCI so that we can be better equipped in order to give these mothers correct information" (FGD 2).*

*I received a training in 2007... (IDI 6).*

In the event that training sessions were conducted, nurses and selected local government workers are responsible for information dissemination to community workers who then educate mothers during routine house-to-house immunization visits.

*"Ideally, health workers who should have been trained on Community IMCI should be the ones responsible for giving the mothers this information" (IDI 2).*

*"The nurses and the Local government staff tell us about immunization, handwashing, environmental sanitation, weaning diet etc." (FGD 1).*

*"It is what the nurse tells us that we tell the mothers in the community" (FGD 3).*

Additionally, it was stated that CHEWs/CORPs are not effectively monitored, leaving them to communicate whatever they deem fit to caregivers.

*"The Local Government staffs only come once in a while and these visits are not even regular, they should come regularly to ensure that the correct information is being given to these mothers" (FGD2).*

*"Monitoring of the health workers is not regular.... So, informants are left alone to say what they want and sometimes they may make mistakes" (IDI 7).*

### **Implementation of C-IMCI in Oyo State**

While some key players in the health sector believe that C-IMCI was being practiced in Oyo state, some others think otherwise.

*"Yes, it's being implemented.... Government is trying, especially the MNCH week which is every year nationwide...and is yielding good result" (IDI 5).*

*"It's being implemented; the only thing is just that there is no proper monitoring" (IDI 8).*

*"It's not being implemented, even the IMCI itself, many health workers are not practicing it. We need sensitization workshops" (IDI 3).*

### **Possible reasons for non-adherence to C-IMCI and recommendations for promoting KHPs**

Respondents were of the opinion that mothers did not prioritize KHPs for reasons such as exposure, concurrent job demand, laziness, illiteracy, poverty etc.

*"Some mothers may not understand how some of these practices can be done. For example, preparing ORS in the home... not every mother can do it" (FGD 1).*

*"Even if the mother wants to adopt these practices, poverty may prevent her from doing it" (FGD 4).*

*"A mother who sells things at the market all day may be too tired to even remember these practices... so she will not be able to perform some of them" (FGD 3).*

Respondents went on to suggest ways in which C-IMC can be promoted, particularly through the involvement of community leaders and government authorities in creating enlightenment on the need to adopt KHPs.

*"Heads and leaders in the community need to encourage women to perform these practices as this will help their children to be healthy" (FGD 4).*

*"Government can organize sensitization rally, maybe quarterly, so that mothers can know about C-IMCI" (IDI 4).*

*"...create enlightenment programmes in the communities for mothers to see the benefits of having healthy children which will ultimately translate to healthy societies (FGD 1).*

## **DISCUSSION**

It was obvious that although many respondents had knowledge on C-IMCI they could not define or explain the term until further clues were given; validating the phenomenon that it is possible to know or practice something without knowledge of the contemporary word or phrase that describes it. This was

however a surprising observation since these groups of respondents is health workers supposedly responsible for training caregivers on KHPs (Ebuehi & Adebajo, 2010). Because they connected with immunization, nursing, and other lone childcare activities more readily, the C-multifaceted IMCI's and synergistic influence on children's health may have been diminished (Gera *et al.*, 2016; García Sierra, & Ocampo Cañas, 2020). One study found that 90% of the community health practitioners surveyed lacked the expertise necessary to deliver high-quality C-IMCI (Stellenberg *et al.*, 2015).

A large number of respondents reported that they lacked access to thorough and current C-IMCI training. Lack of training will obviously have a negative impact on the provision of healthcare because training is the foundation for improved communication between healthcare professionals and caregivers (Moore *et al.*, 2018). The majority of people who had direct contact with caregivers reported there was no system in place for quality control, despite relying on nurses and authorized LGA personnel for information. This is consistent with earlier research's findings (Rowe *et al.*, 2009; Goga & Muhe, 2011; Meno *et al.*, 2019), which showed that concerns about a lack of technical expertise, resources, and supervision were expressed even within the PHC system. Motivation, performance, and job satisfaction all rise with supervision (Arifeen *et al.*, 2004; Horwood *et al.*, 2009). Purposeful observation of the behaviors of trained community health workers will undoubtedly improve their delivery of high-quality services, much as WHO urges IMCI practitioners to be overseen by their trainers through follow-up visits (World Health Organization, 1999).

The divergent views on the level of C-IMCI adoption in Oyo state suggest that the technique may not be common in the area. The IMCI strategy is unable to achieve the best gains for child survival because of partial implementation, which has also been confirmed by other researchers (Boschi-Pinto *et al.*, 2018; Getachew *et al.*, 2021). Other researchers claim that community members' skepticism of IMCI procedures, the attitude of health staff and caregivers, and inadequate money are barriers to IMCI implementation (Boschi-Pinto *et al.*, 2018; Meno *et al.*, 2019; Reñosa *et al.*, 2021). From their perspective, our respondents believed that among other things, poverty, illiteracy, and lack of interest are some of the causes behind mothers' inability to adopt KHPs.

Our findings only apply to two local governments in Ibadan and are context-specific. As a result, it will be necessary to proceed cautiously with generalization to other areas. Future studies may quantify the level of C-IMCI knowledge among CHEWs/CORPs and examine the degree of cooperation between frontline healthcare professionals and

CHEWs/CORPs in carrying out their respective responsibilities.

## CONCLUSION

Implementation of C-IMCI is not widespread in the study area. CHEWs/CORPs and other focal health officers investigated in this study do not receive regular trainings on C-IMCI- as such their knowledge is limited in this regard. Community empowerment is central to the IMCI strategy (Tulloch, 1999; Prost *et al.*, 2018). Improving literacy rates, socioeconomic status and incorporating C-IMCI within existing maternal and child health programs may improve sensitization and acceptability among both healthcare workers and caregivers. Furthermore, since the success of IMCI is any given area is tied to contextual adaption, we recommend that the government invests into local innovative solutions for C-IMCI implementation. Deliberate efforts should be driven in the direction of training, monitoring, and evaluation. Investing in a reward system that recognizes and appreciates the efforts of outstanding health workers will also be a motivation for excellent service delivery.

### What is known about this topic?

- The key role of community resource persons (CORPs) and primary health workers in filling the knowledge gap on C-IMCI in community settings

### What this study adds

- Examining Community-Integrated Management of Childhood Illnesses knowledge among community resource persons/principal health workers and other healthcare professionals,
- Training accessibility and suggestions for Community-Integrated Management of Childhood Illnesses promotion

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### COMPETING INTEREST

The authors declare no conflicting interests.

## REFERENCES

- Adedokun, S. T., & Yaya, S. (2020). Childhood morbidity and its determinants: evidence from 31 countries in sub-Saharan Africa. *BMJ Global Health*, 5(10), e003109. <https://doi.org/10.1136/bmjgh-2020-003109>
- Arifeen, S. E., Blum, L. S., Hoque, D. M. E., Chowdhury, E. K., Khan, R., Black, R. E., Victora, C. G., & Bryce, J. (2004). Integrated Management

- of Childhood Illness (IMCI) in Bangladesh: early findings from a cluster-randomised study. *The Lancet*, 364(9445), 1595–1602. [https://doi.org/10.1016/s0140-6736\(04\)17312-1](https://doi.org/10.1016/s0140-6736(04)17312-1)
- Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2017). Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 195–211. <https://doi.org/10.1007/s10488-017-0815-0>
  - Boschi-Pinto, C., Labadie, G., Dilip, T. R., Oliphant, N., DalGLISH, S. L., Aboubaker, S., Agbodjan-Prince, O. A., Desta, T., Habimana, P., Butron-Riveros, B., Al-Raiby, J., Siddeeg, K., Kuttumuratova, A., Weber, M., Mehta, R., Raina, N., Daelmans, B., & Diaz, T. (2018). Global implementation survey of Integrated Management of Childhood Illness (IMCI): 20 years on. *BMJ Open*, 8(7), e019079. <https://doi.org/10.1136/bmjopen-2017-019079>
  - Ebuehi, O. M., & Adebajo, S. (2010). Improving caregivers' home management of common childhood illnesses through community level interventions. *Journal of Child Health Care*, 14(3), 225–238. <https://doi.org/10.1177/1367493510364167>
  - García Sierra, A. M., & Ocampo Cañas, J. A. (2020). Integrated Management of Childhood Illnesses implementation-related factors at 18 Colombian cities. *BMC Public Health*, 20(1), 4–5. <https://doi.org/10.1186/s12889-020-09216-0>
  - Gera, T., Shah, D., Garner, P., Richardson, M., & Sachdev, H. S. (2016). Integrated management of childhood illness (IMCI) strategy for children under five. *Cochrane Database of Systematic Reviews*, (6). <https://doi.org/10.1002/14651858.cd010123.pub2>
  - Getachew, T., Assebe Yadeta, T., Gereziher, T., Eyeberu, A., & Dheresa, M. (2021). Determinants of maternal knowledge on neonatal danger signs and care-seeking practices in a rural area of southeastern Ethiopia. *International Health*. <https://doi.org/10.1093/inthealth/ihab084>
  - Goga, A. E., & Muhe, L. M. (2011). Global challenges with scale-up of the integrated management of childhood illness strategy: results of a multi-country survey. *BMC Public Health*, 11(1). <https://doi.org/10.1186/1471-2458-11-503>
  - Haines, A., Sanders, D., Lehmann, U., Rowe, A. K., Lawn, J. E., Jan, S., Walker, D. G., & Bhutta, Z. (2007). Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 369(9579), 2121–2131. [https://doi.org/10.1016/s0140-6736\(07\)60325-0](https://doi.org/10.1016/s0140-6736(07)60325-0)
  - Horwood, C., Vermaak, K., Rollins, N., Haskins, L., Nkosi, P., & Qazi, S. (2009). An Evaluation of the Quality of IMCI Assessments among IMCI Trained Health Workers in South Africa. *PLoS ONE*, 4(6), e5937. <https://doi.org/10.1371/journal.pone.0005937>
  - Hug, L., Alexander, M., You, D., & Alkema, L. (2019). National, regional, and global levels and trends in neonatal mortality between 1990 and 2017, with scenario-based projections to 2030: a systematic analysis. *The Lancet Global Health*, 7(6), e710–e720. [https://doi.org/10.1016/s2214-109x\(19\)30163-9](https://doi.org/10.1016/s2214-109x(19)30163-9)
  - Jibo, A. M., Iliyasu, Z., Abubakar, I. S., Umar, L. M., & Hassan, A. M. (2014). Community-integrated management of childhood illnesses (C-IMCI) and key household practices in Kano, Northwest Nigeria. *Sub-Saharan African Journal of Medicine*, 1(2), 70.
  - Liu, L., Oza, S., Hogan, D., Chu, Y., Perin, J., Zhu, J., Lawn, J. E., Cousens, S., Mathers, C., & Black, R. E. (2016). Global, regional, and national causes of under-5 mortality in 2000–15: an updated systematic analysis with implications for the Sustainable Development Goals. *The Lancet*, 388(10063), 3027–3035. [https://doi.org/10.1016/s0140-6736\(16\)31593-8](https://doi.org/10.1016/s0140-6736(16)31593-8)
  - Meno, F. O., Makhado, L., & Matsipane, M. (2019). Factors inhibiting implementation of Integrated Management of Childhood Illnesses (IMCI) in primary health care (PHC) facilities in Mafikeng sub-district. *International Journal of Africa Nursing Sciences*, 11, 100161. <https://doi.org/10.1016/j.ijans.2019.100161>
  - Moore, P. M., Rivera, S., Bravo-Soto, G. A., Olivares, C., & Lawrie, T. A. (2018). Communication skills training for healthcare professionals working with people who have cancer. *Cochrane Database of Systematic Reviews*, 7(7). <https://doi.org/10.1002/14651858.cd003751.pub4>
  - Mukunya, D., Kizito, S., Orach, T., Ndagire, R., Tumwakire, E., Rukundo, G. Z., Mupere, E., & Kiguli, S. (2014). Knowledge of integrated management of childhood illnesses community and family practices (C-IMCI) and association with child undernutrition in Northern Uganda: a cross-sectional study. *BMC Public Health*, 14(1). <https://doi.org/10.1186/1471-2458-14-976>
  - Nguyen, D. T. K., Leung, K. K., McIntyre, L., Ghali, W. A., & Sauve, R. (2013). Does Integrated Management of Childhood Illness (IMCI) Training Improve the Skills of Health Workers? A Systematic Review and Meta-Analysis. *PLoS ONE*, 8(6), e66030. <https://doi.org/10.1371/journal.pone.0066030>
  - Ogundele, O. A., Ogundele, T., Olajide, O. S., & Agunbiade, O. I. (2016). Effect of community integrated management of childhood illness on mothers' healthcare-seeking behaviour and home management of childhood illness in Ile-Ife, South-West Nigeria: A household survey. *South African Journal of Child Health*, 10(1), 16–19. <https://doi.org/10.7196/sajch.2016.v10i61.912>

- Ophori, E. A., Tula, M. Y., Azih, A. V., Okojie, R., & Ikpo, P. E. (2014). Current Trends of Immunization in Nigeria: Prospect and Challenges. *Tropical Medicine and Health*, 42(2), 67–75. <https://doi.org/10.2149/tmh.2013-13>
- Prost, A., Sanders, D., Costello, A., Vogel, J., Baqui, A. H., Nair, N., Romedenne, M., Chitnis, K., Bisoborwa, G., & Doherty, T. (2018). Strengthening the capabilities of families and communities to improve child health in low and middle income countries. *BMJ*, bmj.k2649. <https://doi.org/10.1136/bmj.k2649>
- Reñosa, M. D. C., Landicho, J., Wachinger, J., Dalglish, S. L., Bärnighausen, K., Bärnighausen, T., & McMahon, S. A. (2021). Nudging toward vaccination: a systematic review. *BMJ Global Health*, 6(9), e006237. <https://doi.org/10.1136/bmjgh-2021-006237>
- Rowe, A. K., Onikpo, F., Lama, M., & Deming, M. S. (2009). The rise and fall of supervision in a project designed to strengthen supervision of Integrated Management of Childhood Illness in Benin. *Health Policy and Planning*, 25(2), 125–134. <https://doi.org/10.1093/heapol/czp054>
- Shrivastava, S. R., Shrivastava, P. S., & Ramasamy, J. (2013). Integrated Management of Childhood Illness: bringing treatment closer to home. *Progress in Health Sciences*, 3(2), 187-190.
- Stellenberg, E., Van Zyl, M., & Eygelaar, J. (2015). Knowledge of community care workers about key family practices in a rural community in South Africa. *African Journal of Primary Health Care & Family Medicine*, 7(1). <https://doi.org/10.4102/phcfm.v7i1.892>
- Tulloch, J. (1999). Integrated approach to child health in developing countries. *The Lancet*, 354, S1116–S1120. [https://doi.org/10.1016/s0140-6736\(99\)90252-0](https://doi.org/10.1016/s0140-6736(99)90252-0)
- World Health Organization. (1999). *Guidelines for follow-up after training in the WHO/UNICEF Course of Integrated Management of Childhood Illness for First-Level Health Workers*. Apps.who.int. <https://apps.who.int/iris/handle/10665/66095>
- World Health Organization. (2022). *Child mortality and causes of death*. Wwww.who.int. <https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/child-mortality-and-causes-of-death>
- Yaya, S., Ekholuenetale, M., Tudeme, G., Vaibhav, S., Bishwajit, G., & Kadio, B. (2017). Prevalence and determinants of childhood mortality in Nigeria. *BMC Public Health*, 17(1). <https://doi.org/10.1186/s12889-017-4420-7>
- You, D., Hug, L., Ejdemyr, S., Idele, P., Hogan, D., Mathers, C., Gerland, P., New, J. R., & Alkema, L. (2015). Global, regional, and national levels and trends in under-5 mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Inter-agency Group for Child Mortality Estimation. *The Lancet*, 386(10010), 2275–2286. [https://doi.org/10.1016/s0140-6736\(15\)00120-8](https://doi.org/10.1016/s0140-6736(15)00120-8)

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