The impact of advocacy and community mobilization on the utilization of health services at the Comprehensive Health Centre, Gindiri.

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Abstract

Primary Health Care facilities provide promotive, preventive, curative and rehabilitative services to a community. They may be well built and equipped with adequate resources but grossly underutilized due to several factors.
Health records at the Comprehensive Health Centre Gindiri for 2005 were compared with those of 2007 after a well-coordinated advocacy and mobilization programme in that community.
The results show that the total out patient attendance in 2007 increased by 220.6% when compared to that of 2005. 293 patients were admitted into the wards in 2005 compared to 813 in 2007(277%). There was no surgery carried out in the whole of 2005, whereas in 2007 there were 98 surgeries.
Advocacy and community mobilization could be important factors in the utilization of primary health services.

Introduction

Comprehensive Health centres are Primary Health Care facilities providing promotive, preventive, curative and rehabilitative services to a community. They may be well built and equipped with adequate resources human, material; and well funded with tax payers money, but grossly underutilized due to several factors that may be economic, educational, geographical, sociocultural, political, legal or religious.[1, 2, 3] The attitude of health workers, availability of doctors, irregular supplies and commodities and inefficient service delivery are other strong factors affecting utilization of these health services.1,2,3 In Africa, up to 80% of the population uses traditional medicine for primary health care.[4] Eighty-five per cent of Nigerians use and consult traditional medicine for healthcare, social and psychological benefits.[5, 6] In rural Burkina Faso, modern health care facilities are only consulted by 19% of the population; others choose home treatment (52%), traditional healers (17%), or local village health workers (5%). This translates in a utilization of government services as low as 0.17 consultations per capita in 1997.3 In Ghana, Mali, Nigeria and Zambia, herbal medicines are the first line of treatment for 60 per cent of children with high fever from malaria.[5] About 60-85 per cent of births delivered in Nigeria and especially in the rural communities are by the Traditional Birth Attendants and these take place outside the Health facilities.[6,10] Many patients prefer to seek care at the patent medicine stores or with the traditional medicine operators instead of the formal health sector.[3]

Community mobilization and participation are known to play a key role in utilization of health services, by ensuring ownership and sustainability of health programmes and interventions. It involves encouraging the community to take part in their health care and development. It is a lengthy process and not only implies that the community members, government and NGOs come together to develop a strategy to resolve issues within the community, but also entails the pooling of their resources. A key component of community mobilization involves identifying and developing leaders from the community by strengthening and building their capacities in various issues. Community mobilization is neither a campaign that is undertaken once, nor is it a series of campaigns carried out over a period of time. It is a continual and cumulative communication through educational and organizational processes that produces a growing autonomy and consciousness in the community about taking development into their hands. Such efforts need to be sustainable and sustainability of social change is more likely if the individuals and communities have a sense of ownership in the development process and that communities should be the agents of their own change. The communities should be mobilized to participate in their development or health activities from the planning to implementation, monitoring and evaluation phases to ensure ownership and sustainability. The establishment of health development committees is one way of ensuring community participation and could be used to mobilize the community.

The Comprehensive health Centre Gindiri, is one of the Rural Health centers established by the Jos university teaching Hospitals in 1988 and commissioned in April 1990 to provide comprehensive Primary health care to the people of Gindiri in Plateau state. The management of the Jos University teaching Hospital recently, in the year 2006 appointed a Community physician as the medical superintendent to oversee the management of the hospital. He was charged with the responsibility of improving the utilization of the hospital and its revenue base. One of the strategies adopted by the new management at the health centre was advocacy and the mobilization of the host communities from February 2006.

There were also efforts to improve staff strength and the motivation of the health workers through renovation of staff quarters and continuous medical development.

Methods

This is a retrospective study. Health records at the Comprehensive health centre Gindiri showing out patient attendance by adult males and females, and paediatric cases

Month	2005	2007
January	48	148
February	50	189
March	70	165
April	49	171
May	64	212
June	135	177
July	107	166
August	89	150
September	65	184
October	132	179
November	124	220
December	76	190
Total	1009	2151

Table 1: Monthly Adult Male Outpatient Attendance at Comprehensive Health Centre Gindiri in 2005 and 2007

Month	2005	2007
January	60	303
February	80	305
March	100	325
April	71	276
May	97	431
June	150	299
July	169	333
August	140	260
September	105	280
October	129	271
November	88	325
December	95	282
Total	1284	3690

Table 2: Monthly Adult Female Outpatient Attendance at Comprehensive Health Centre Gindiri in 2005 and 2007

	2005	2007
Adult males	1009	2151
Adult females	1284	3690
Paediatric	1325	2142
Total	3618	7983

Table 3: Total outpatient attendance at Comprehensive Health Centre Gindiri in 2005 and 2007

(<15 years old) in 2005 were compiled and summarised. These records were compared with those obtained in 2007 after a well coordinated advocacy and mobilization programme in the same community. The numbers of admissions during the same period were also examined

Results and Discussion

The results show that there were a total of 1,009 male outpatients in 2005. This increased to 2151 in 2007 (Table 1). A total of 1,284 female outpatients were seen in 2005 and this had increased by 287% in 2007 (Table 2). With regards to paediatric outpatients, 1,325 patients were seen in 2005, however by 2007, 2142 cases or an increase of 161% was recorded (Table 3). By 2007 the total outpatient attendance had increased by 220.6% compared to the attendance in 2005. 293 patients were admitted into the wards in 2005 compared to 813 in 2007 (Figure 1). Records also showed that there was no surgery carried out in the whole of 2005, whereas in 2007 there were 98 surgeries. These improvements in the utilization of services at the Comprehensive Health Centre, Gindiri followed the intensive and organized continuous community mobilization and advocacy commenced February 2006.

Conclusion

This study shows that Advocacy and community mobilization could be important factors in the utilization of primary health services, especially in combination with other efforts to strengthen manpower and service delivery. These factors may have confounded this study.

We strongly recommend that health managers should engage in active, purposeful and continuous advocacy and mobilization of the community so as to promote ownership and sustainable improvement in the utilization of health services. This will complement other efforts such as manpower capacity development, infrastructural development, attitudinal reorientation and provision of essential drugs and commodities, directed at improving efficiency and efficacy of the health system.

Further controlled or experimental studies may reduce the confounders in this study.

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