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. 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. In Africa, up to 80% of the population uses traditional medicine for primary health care. Eighty-five per cent of Nigerians use and consult traditional medicine for healthcare, social and psychological benefits. 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. 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. 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. Many patients prefer to seek care at the patent medicine stores or with the traditional medicine operators instead of the formal health sector. 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
Primary health services, especially in combination with
improvements in the utilization of services at the
programme in the same community. The numbers of
admissions during the same period were also examined
These records were compared with those obtained in 2007
(Table 3). By 2007 the total outpatient attendance
to paediatric outpatients, 1,325 patients were seen in 2005,
this had increased by 287% in 2007 (Table 2). With regards
1). A total of 1,284 female outpatients were seen in 2005 and
outpatients in 2005. This increased to 2151 in 2007 (Table
These factors may have confounded this study.
Further controlled or experimental studies may reduce the
confounders in this study.
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Communities’ Awareness, Perception and Participation in the
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Table 1: Monthly Adult Male Outpatient Attendance at
Comprehensive Health Centre Gindiri in 2005 and 2007

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<td>Adult males</td>
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<td>Adult females</td>
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<td>Total</td>
<td>3618</td>
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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.

Table 2: Monthly Adult Female Outpatient Attendance at
Comprehensive Health Centre Gindiri in 2005 and 2007
Prevalence and risk factors of low birth weight in Jos

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Abstract

This study examines the Prevalence and factors associated with low birthweight (LBW) in Jos. 208 babies delivered by 208 women in Jos University Teaching Hospital, (JUTH) were studied over an eight week period (12th February to 11th April 2003). A cross-sectional study was done and the sample gotten by systematic sampling of all the babies delivered. Mean birth weight of the infants was 3.08±1.319 (range 0.904 to 4.005) kg. The prevalence of LBW was found to be 12.7%. LBW has bivariate associations with mother’s educational status, height, and health problems during pregnancy, use of antenatal care facilities, and gestational age. No association was found between LBW and mother’s occupation. Although antenatal care provision is absolutely necessary, intervention approaches that go beyond clinical or primary care settings are also warranted for better nutrition of women. Concerted efforts in health and non-health sectors are necessary for improvement in health and social status of women in order to reduce low birthweight.

Introduction

In 1948, the first World Health Assembly adopted an international definition of prematurity as birth weight of 2,500 grams or less. 1 It was however discovered that in developing countries the use of this standard resulted in an unusually high proportion of ‘premature’ babies most of whom were not born prematurely. The World Health Organization (WHO) then conducted a study on eighteen different countries at different stages of development. This revealed that babies could be classified into three main groups based on their birth weight and gestational age: small for gestational age, appropriate for age, large for age. Low birth weight was then defined as those babies weighing less than 2,500 grams within twenty four hours of birth. This group of babies can either be small for age or appropriate for age and they are usually at high risk of dying in their first twenty eight days of life from factors like hypoglycemia, sepsis, respiratory distress, prematurity etc. In Nigeria, neonatal death (death of an infant in the first twenty eight days of life) contributes about 25% of the total infant mortality with prematurity and low birth weight being the main contributor to these high neonatal deaths.2

A reduction of at least one-third in the proportion of infants with low birth weight is one of the seven major goals for the current decade of the “A World Fit for Children” programme of the United Nations. Moreover, nutritional deprivation — the major determinant of low birth weight — is a clear obstacle to the attainment of many of the Millennium Development Goals 1. Monitoring improvements in low birth weight is thus being given high priority within the UN system, as well as by national governments and the international nutrition community.

Although the significance and interpretation of low birth weight has recently been debated 3–5, most experts agree that weight at birth is an indicator of a newborn’s chances for survival, growth, long-term health and psychosocial development 6. Babies whose birth weight is low as a result of undernourishment face a greatly increased risk of death during their first months and years of life 6–8. The evidence also suggests that those children who do survive may be more likely to experience health problems throughout their lives; these include impaired cognitive development, as well as diabetes and coronary heart disease in adulthood 9, 10. Low birth weight in developing countries occurs primarily because of poor maternal health and nutrition. A variety of socioeconomic, medical, and psychosocial factors are known to increase the risk of low birth weight,6-9 but prevention programs aimed at primarily high-risk subgroups have been largely ineffective.

In addition, diseases such as diarrhoea, malaria and respiratory infections, which are common in many developing countries, can significantly impair fetal growth when women become infected during pregnancy 6, 7. In Nigeria just like in many developing countries, low birth weight is a significant contributor to the overall infant mortality rate and a major factor in the high neonatal mortality rate currently seen,12,11,2. An understanding of the prevalence and also the factors contributing and sustaining the problem will go a long way in addressing this significant cause of neonatal mortality with the aim of reducing it and attaining the Millennium development goals.

Materials and Methods

This prospective study was conducted at the labour room of the Jos University Teaching Hospital, Jos Nigeria. It is a 500-bed tertiary Hospital in north central Nigeria, whose