

Roles of Advocacy and Community Mobilization on Utilization of Sexual and Reproductive Health Services at Garba Buzu Community, Maiduguri, Borno State

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Abstract

This study was conducted to assess the roles of advocacy and community mobilization in utilization of Sexual and Reproductive Health (SRH) services in Garba Buzu community, Maiduguri, Borno State, Nigeria. Two objectives guided the study. Survey research method was used. Research Instruments used for this study were Focused Group Discussion (FGD) and Interview grids. Purposive sampling technique was used in selecting FGD participants while quota sampling was used in selecting interview participants. Data were analysed using thematic analysis. Findings of the study revealed that roles of advocacy and community mobilization in utilization of SRH services is paramount. It was concluded that increase in service utilization from 2021 to 2022 in the study area was as a result of coordinated advocacy and community mobilization. It was recommended that SRH managers should provide conducive atmosphere for community mobilization by community health volunteers at Garba Buzu community.

Key Words: Advocacy, Community Mobilization, Sexual and Reproductive Health, Utilization

Introduction

Sexual and Reproductive Health (SRH) is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the sexual and reproductive system and to its functions and processes (Adongo et al 2013). Sexual and Reproductive Health of women of child bearing age is a key indicator for national growth and development. It connotes the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable SRH services of their choice, and the right of access to appropriate services that will enable them to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant, (Adongo et al 2013). It is the constellation of methods, techniques and services that contribute to sexual and reproductive well-being through preventing and solving reproductive health problems; its purpose is to enhance life and personal relations, and not merely counselling and care related to sexual and reproduction health and sexually transmitted diseases prevention (Omobuwa et al 2012)

Basic Sexual and Reproductive Healthcare services that are provided at primary healthcare clinics include Antenatal Care (ANC), Postnatal Care (PNC) and Family Planning (FP). Antenatal care

(ANC) and postnatal care (PNC) are critical opportunities for women, babies, parents/caregivers and families to receive quality care (Dada et al 2021). In 2016, the World Health Organization (WHO) released updated recommendations for routine ANC within the continuum of care to improve maternal and new-born health. The WHO recommendations for PNC, published in 2013, are currently being updated (Dada et al, 2021). With global priorities to improve the availability, accessibility and acceptability of these care, a range of studies have investigated the factors that affect the implementation of these guidelines and the utilization of all SRH services.

ANC and PNC share common factors that may affect their uptake and utilization, including providers' skills, the relationship between health workers and women, local infrastructure such as distance and transportation to facilities, as well as the influence of women and families' knowledge, attitudes, beliefs and culture norms regarding care (Dada et al, 2021). Study conducted Adah et al, 2020) revealed that ignorance, 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. Eighty-five per cent of mothers

use and consult traditional birth attendants on matters relating to Sexual and Reproductive health (Adah et al, 2020). In rural Burkina Faso, SRH services in modern health care facilities are only consulted by 19% of the population; others choose home treatment (52%), traditional Birth Attendants (17%), or local village health workers (5%) (Adah et al, 2020). This therefore called for the advocacy and community mobilization to improve uptakes of conventional SRH and other healthcare services in developing countries, including Nigeria.

Community mobilization and advocacy are an organized strategies that can be used to facilitate social, behavioural, and structural change in a community. In contrast to traditional programmatic interventions, community mobilization and advocacy focus on uniting a community around a single issue to create social and systemic change as envisioned by the community (Altman et al. 2015). It involves different strategies ranging from mass awareness campaign, Focused Group Discussions, radio jingles, meetings with stakeholders and door-to-door sensitization on health topics, including sexual and reproductive health (Howard-Grabman & Snetro, 2015). Community stakeholders, rather than an outside entity, determine the goals, priorities, and timeline of the mobilization process, often through an organized leadership or steering committee process. Any outside support for community mobilization and advocacy is provided with the intention of building the community's capacity for long-term sustainable change. Community is said to be mobilized once participation has taken place, (Altman et al, 2015).

Community mobilization is key in reducing barriers to SRH utilization. It can be considered as a direct or indirect process of involving communities in decision making and/or in the planning, design, governance, and delivery of services using methods of consultation, collaboration, and/or community control (Department For International Development[DFID], 2017). Different approaches commonly used include providing health education through materials, meetings and outreach visits, provision of incentives using community structures, mobilising human resources, involvement of local opinion leaders and spreading messages through mass media (DFID, 2017). Participation of community members in boasting sexual and reproductive healthcare utilization is not new with many tracing its emergence to the declaration of Alma-Ata in 1978 and earlier (DFID, 2017). At a global policy level, community mobilization and advocacy continue to be viewed as important for health improvement and is commonly recommended in international conferences and charters, for example in the World

Health Organization (WHO) Rio Political Declaration on Social Determinants of Health (World Health Organization, 2014).

Community mobilization and advocacy are known to play a key role in utilization of health services, by ensuring ownership and sustainability of health programmes and interventions (Altman et al, 2015). 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 for the attainment of set goals (Brian et al, 2016). Greenberg et al (2017) opined that Community mobilization and advocacy promote greater sustainability over long term than do traditional programmatic interventions on sexual and reproductive health services. It draws on the expertise and strengths of community members, resulting in interventions that do not depend on outside support. The collaboration that emerges from community mobilization and advocacy can limit competition and redundancy of sexual and reproductive health services, improving the quality and breadth of services offered without necessarily requiring an influx of funding. In addition, it results in a shift in social norms in the community, which allows the community to approach issues differently over the long term. (Greenberg et al, 2017). The WHO guidelines for Maternal and New-born Health (MNH) indicated that community-based interventions (community mobilization and advocacy) promote services uptake, knowledge, attitude and practice via the use of different strategies that include participatory learning and action (PLA) cycles, (WHO, 2014).

Findings of a study conducted by Karuga, Kok, and Dieleman (2022) revealed that community mobilization and advocacy play important roles in primary healthcare services uptake; including sexual and reproductive service. Furthermore, systemic review by DFID (2017) in low and middle income countries indicated that the roles of community mobilization and advocacy in sexual and reproductive health service utilization cannot be underestimated. It showed that well-coordinated community mobilization and advocacy activities can go a long way in preventing complication due to childbirth; which usually happens as a result of home delivery.

Investigation by the researchers revealed that there was variation in number of persons that utilized SRH services at Garba Buzu community between 2020 and 2022. This is summarized as presented in table below:



Table 1: Number of Persons that Utilized Antenatal Care, Postnatal Care and Family Planning Services at Garba Buzu Community Clinic from 2020 to 2022

S/N	Service	Year and % Change				
		2020	% Change	2021	% Change	2022
1.	ANC	29400	96.22	39022	13.45	46645
2.	PNC	4656	17.53	6409	-6.76	5733
3.	FP	1675	-4.61	1214	-7.36	478
TOTAL		35731		46645		46578

Source: State Primary Healthcare Development Agency (SPHCDA, 2023)

It is therefore against this background that this study is designed to assess the Roles of Advocacy and Community Mobilization on Utilization of Sexual and Reproductive Health Services at Garba Buzu Community, Maiduguri, Borno State, Nigeria.

Objectives of the study

The objectives of this study are to assess:

- 1) Roles of Advocacy on utilization of Sexual and Reproductive Health Services at Garba Buzu community, Maiduguri, Borno State.
- 2) Roles of community mobilization on utilization of Sexual and Reproductive Health Services at Garba Buzu community, Maiduguri, Borno State.

Methods

This study employed survey research design. The design deals with collecting and analyzing data from only few people or items considered to be representative of the entire group, (Krosnick, 2018). The study was conducted at Garba Buzu community, Maiduguri. The community is served by a primary health clinic that was established in the year 2016 due to increased need for healthcare services as a result of influx of people from neighbouring local government areas to the metropolis due to Boko Haram insurgency. The clinic provides Primary Healthcare services to both members of the Host Community and Internally Displaced Persons (IDPs). It is operated by Non-governmental Organization in collaboration with the state Ministry of Health and State Primary Healthcare Development Agency. Purposive sampling technique was used in selecting nine FGD participants while quota sampling was used in selecting five community leaders, five community volunteers and two midwives. Research instruments used for this study were FGD and Interview grids. Focused Group Discussion was held with nine sexual and reproductive health services beneficiaries in the community. Interview was also conducted with two midwives and five community volunteers. Five community leaders who are stakeholders in the community were also interviewed. In-depth thematic analysis on FGD and interview data was conducted.

Results

Roles of Advocacy and Community Mobilization on Utilization of Sexual and Reproductive Health Services from 2020 to 2022 at Garba Buzu Community

Results on FGD (with female beneficiaries in the community), Interview (with community stakeholders and volunteers), and interview with midwives working in the clinic are presented below:
"...at the eve of the Covid-19 pandemic, we witnessed mass awareness raising on health services that made a lot of us to visit the clinic for all services rendered (female FGD participant)"

This implies that integrated awareness raising after the COVID-19 pandemic made females to patronize services in the clinic, included SRH services.

"...in the year 2021 after many organizations were here on advocacy and referrals. Coupled with the fear of covid-19, we usually go for our ANC visits as instructed (female FGD participant)"

This implies that roles played by local and international NGOs in advocacy and community mobilization was key in the utilization of SRH services.

"...we were very careful of any abnormal change in our bodies, and that made all pregnant and lactating mothers to visit the SRH unit of the clinic for proper assessment and care, we fear the covid-19 (female FGD participant)"

This indicates that because of bridged knowledge gap as a result of advocacy, women became conscious of body change and utilized SRH services in the close-by clinic.

"...Our husbands used to inform us of the meetings they had with the clinic staff. That made us to visit the

SRH unit of the clinic for fear of the unknown (female FGD participant)

This shows the enormous role of advocacy that resulted in community participation of spreading information in the community. That went a long way in promoting service patronage as informed by the participant. Husbands and other community members joined the band wagon in disseminating acquired health information and knowledge about SRH services.

“...series of radio jingles on covid-19 and healthcare including SRH were been done. We adhered to the advice heard from those sources which made us to visit the clinic on time (female FGD participant)”

Advocacy on radio is a mean through which service utilization is promoted. This is evidenced by submission of this participant.

“...the years preceding the Covid-19 outbreak was a year of fear and care. We had series of meetings with many NGOs on health. Information received are usually transmitted to our families to avoid any form of eventuality” (male community stakeholder).

This invariably shows that meeting with community leaders as an advocacy and community mobilization strategy helped a lot in SRH services uptake.

“...our children were recruited that time to create awareness on health. We did not hesitate to visit the clinic because of the work being done by our own children” (male community stakeholder).

“...why won't pregnant mothers go to for SRH services? We had female daughters recruited by the clinic and they went door-to-door telling people to come out for free medical services” (male community stakeholder).

This indicates that community mobilization using community members helped a lot in SRH service utilization.

“... Pregnant mothers were much worried about covid-19 and the fact that pregnancy reduces the body immunity, so they didn't play with their visit schedules” (male community volunteer)

“...you know, there were many organizations that we collaboratively worked with on advocacy. We informed women that PNC is key for prevention of disease in neonate. They usually came as expected in the clinic to get care, to get vaccines” (male community volunteer).

This shows the roles of door-to-door advocacy strategy in utilization of SRH services.

“... We were into mass campaign on health and SRH. The mother did not hesitate to visit the clinic. They agreed with our information because we were part of the community, they knew us. We gave referrals to the SRH unit when service is needed” (female community volunteer).

“...because of the large number of community volunteers, we conducted door-to-door sensitization and checked their ANC cards. We referred when it is time for next visit” (female community volunteer)

“... Yes advocacy and community mobilization was key in SRH service uptake. The volunteers we had worked with the community members in terms on awareness raising. Knowledge gap was bridged and there was compliance with visit schedules” (midwife working in the health facility).

“... You know at times women lack information on essential services like SRH. But with the fear of Covid-19 and associated issues, information was spread like fire. Mothers usually visit the clinic to ensure prevention and care were instituted, we worked with the volunteers and community members via meetings” (midwife working in the health facility).

This implied that roles played by the community members and community volunteers in promoting trust and utilization of SRH services.

Discussion

Findings of this study indicated that roles of advocacy and community mobilization in the utilization of sexual and reproductive health services in the study area cannot be underestimated. This is evidenced by responses of the FGD participants, community stakeholders, community volunteers and midwives that work in the health facility. This finding is in line with that of Adongo et al (2013) on the roles of community-based health planning and services strategies in involving males in the provision of family planning services in southern Ghana. It is also in line with findings of a study conducted by Muzyamba (2018) on the role of community mobilization in the promotion of maternal health of women living with HIV in Zambia which revealed that community mobilization and advocacy strategies such as door-to-door sensitization, Focused Group Discussions, meetings with community stakeholders are essential strategies in maternal health services uptake among the Zambians. Furthermore, the finding corroborates opinion of Dada et al (2011) that the roles of community mobilization and advocacy activities resulted into ownership and community involvement in matters relating to sexual and reproductive service utilization by community members. The finding is also in line with that of studies conducted by Cornish et al (2014) on Impact of Community Mobilisation on HIV Prevention in middle and low income countries and Adhikhari et al (2016) on Community engagement and population coverage in mass anti-malarial administrations which showed that community mobilization and advocacy is

essential tools for service uptake among people in low and middle income countries.

Conclusion

Based on findings of this study, it is concluded that increase in sexual and reproductive health service utilization from 2021 to 2022 at Garba Buzu community, Maiduguri, Borno State, was as a result of the coordinated roles of advocacy and community mobilization.

Recommendation

Based on findings of this study, the following recommendations are proposed:

1. Sexual and Reproductive Health managers should provide conducive atmosphere for community mobilization by community health volunteers.
2. There should be collaborative efforts between stakeholders on advocacy relating SRH services in the study area.
3. Culture-friendly Information, Education, and Communication (IEC) materials should be designed and used for community mobilization activities in the study area.
4. The use of radio jingles as a means of raising awareness on SRH and other healthcare services should be sponsored by relevant stakeholders.

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