Texila International Journal of Public Health
ISSN: 2520-3134
DOI: 10.21522/TIJPH.2013.11.01.Art002

Factors Associated with the Low Facilities Visit: The Real Expectations of Patients in Cameroonian's Context

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Abstract

The health district of Mfou is one of the 29 health districts for the Central region of Cameroon. In 2014, the attendance rate of its facilities was 41%, lower than the 80% norm of the Togolese Ministry of Health in 2013. Questioning the factors associated with this low attendance necessitated the identification of links and associations between it and social demographic factors, health satisfaction, and the perception of facilities by the population. To identify factors associated with low attendance in the Mfou Health District. This is a quanti-qualitative, descriptive cross-sectional study that took place from June 15 to September 22, 2018, in the 32 health facilities in the Mfou Health District. The data collection was based on medical consultation records for 84231 enrolled persons, 372 questionnaires administered to patients in health facilities, and 5 patients who underwent interviews. The data analysis was carried out using CSPro 6.2, Survey CTO Collect v2.41, and SPSS 21 software and the manual operation of the audio content of the interviews. This study shows that the attendance rate of health facilities in the health district of Mfou remains low: 39% in 2015 and 42% in 2017. The factors associated with low attendance at health facilities are the lack of health insurance, the rural environment, the poor quality of reception, the low dynamism of community health workers, the high cost of care and services, the need to have a family relative or an acquaintance working in the Hospital and going to the Hospital only when the illness seems serious with a (P< 5%). The low attendance of health facilities in the Mfou health district remains a major public health concern. This is associated with many factors for which the involvement of communities is necessary and their inclusion in the development of health policies.

Keywords: *Factors Associated with Low Attendance of Health Facilities, Health Facilities, and Health Districts.*

Introduction

The attendance rate of health facilities is a result indicator that determines the acceptability and accessibility of health facilities [1]. This indicator is witness to all the steps taken to improve the health of the population. Globally, about 80% of maternal deaths are due to low attendance at health facilities, making it difficult to manage pregnancy with diseases such as malaria [2]. In Africa, calculations of the attendance rate of health facilities, give very low values, including 34% in Burkina Faso, 30% in Benin, and 24% in Mali [3]. In Cameroon, the reference health facility in the Bonassama health district in Douala reveals an attendance rate of 10% in 2002 and 13% in

Received: 29.06.2022 ***Accepted: 29.07.2022*** ***Published on: 30.03.2023***

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2006 [4]. In the Health District of Ebolowa in 2010, only 1/3 of the women who initiated the first prenatal consultation (PNC) persisted until the third PNC [5]. Attendance at health facilities in the Health District of Mfou in the Central region of Cameroon remains low. Valued at 41% in 2014 [6], it is very far from the 80% norm [7]. Each year, considerable funds, equipment, and people are allocated to the health structures to enable them to improve the care of the population and to sustain the health districts. In this relationship, service provider-client, and indeed human, without visits to the health facilities, the sanitary department will not be self-sufficient and will not continue to satisfy its population. Nevertheless, in Cameroon, mitigation strategies focus on the establishment of health facilities in a disparate manner across the country. This study proposes an innovative approach by asking the population to know why it deserts health facilities; District Hospitals (HD), District Medical Center (CMA), Integrated Health Center (CSI) for first-line use of traditional healers, illegal health centers and self-medication.

Materials and Methods

It is a descriptive cross-sectional study. It necessitated qualitative and quantitative approaches and both prospective and retrospective surveys. The ground survey was carried out in the health facilities of the Mfou district from 15 June to 22 September 2018. Patients who visited the health facilities from January 2015 to December 2017 and from 15 June to 22 September 2018 were the target population [8]. All nonresident and juvenile participants from the Mfou health district were excluded.

The data collection was done from the medical consultation registers through the administration of a questionnaire and an interview guide. The Lorenz formula at a p = 41% allowed us to obtain 372 participants who were submitted to the questionnaire, by data saturation 5 were interviewed, and 84231 were exhaustively recorded in the registers for the years 2015, 2016 and 2017.

The collected data were compiled and analyzed using CSPro 6.2, Survey CTO Collect v2.41, and SPSS 21 statistical analysis software. The data entry mask initiated under CSPro provided a numeric transcription of the paper information. The actual analysis performed with the Statistical Package for Social Sciences (SPSS) required univariate, bivariate, and multivariate analysis. The association between the dependent variable and the independent variables was made using the Chi-Square test. A probability (P) <5% has been used as the significance threshold. It was coupled to an Odd Ratio (OR) within a 95% confidence interval result of the exact Monte Carlo test. The results were presented in terms of numbers and percentages. The charts and graphs were developed using the Microsoft Office Excel software version 2016. This analytical approach was coupled with a manual analysis of the audio content of the interviews. To illustrate the results of this study clearly and intelligibly, the triangulation technique was convened [9].

Results

Socio-demographic Characteristics

The first part of this study was a retrospective approach, which involved the entire patient recorded for consultation in the health care facilities. 84231 patients were recorded in the health facilities of the District of Mfou between 2015 and 2017 at the retrospective investigation. The prospective study showed a response rate of 74.4% (n = 372) because to obtain the 372 required participants according to the Lorentz formula, it was necessary to address 500 individuals. This study involved 37% (n = 139) of men and 62.6% (n = 233) of women. This study grouped 17.5% (n = 65) of adolescents and 82.5% (n = 307) of adults.

Variation in the Attendance Rate of Health Facilities in the Health District of Mfou Between 2015 and 2017

The annual attendance rate of the Mfou Health District is 39% (n = 26808) in 2015, 41% (n = 28412) in 2016 and 42% (n = 29011) in 2017 (Figure 1).

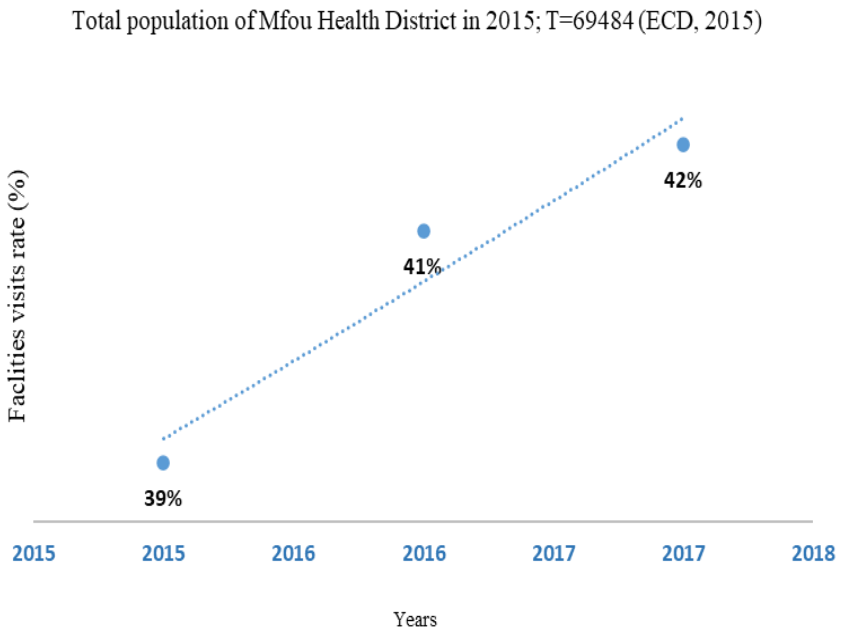

Figure 1. Annual Attendance Rate of the Mfou Health District Between 2015 and 2017

The attendance rate is 91% (n = 11688) in 2017 in the Mfou health area in urban areas and below 57% in other rural health areas (Figure 2).

Reception

76.3% (n = 200) of participants who do not attend health facilities are not satisfied with the reception (Table 1).

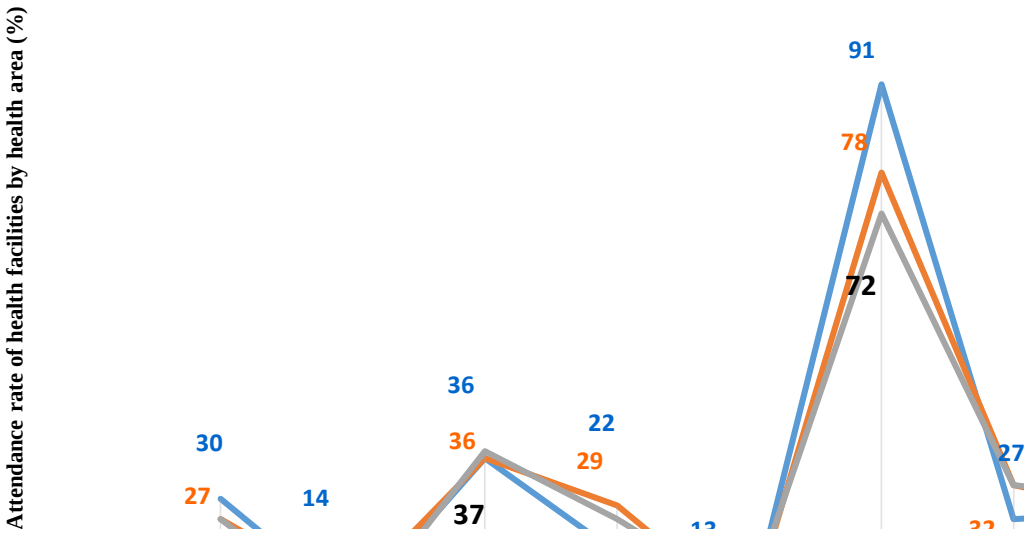

Figure 2. Annual Attendance Rate by Health Areas Between 2015 and 2017

Table 1. Relationship between Reception and Attendance of Health Facilities

Non-attendance of health care facilities			
Variables	**Modality**	**Frequency**	**(%)**
Satisfied with the welcome	Yes	62	56,4
	No	200	76,3

* Significant variables

Motivation of Health Workers

We found out that 75.8% (n = 219) of non-attending participants are unaware of the existence of a community health worker and 75.4% (n = 205) of them do not know the hours of operation of the health center (Table 2).

Table 2. Relationship between Attendance at Health Facilities and Motivation of Health Workers

Non-attendance of healthcare facilities			
Variables	**Modality**	**Frequency**	**(%)**
Knowledge of the presence of community health workers in your community	yes	43	51,8
	no	219	75,8
Is there always someone in the health facilities	yes	40	54,1
	no	17	65,4
	Don't know	205	75,4
	occasionally	26	76,5

* Significant variables

Financial Accessibility

The results show that 68.3% (n = 226) of non-attending participants estimate that the consultation fees are high, most of them having more than 5000 FCFA (LOCAL CURRENCY IN CAMEROON) of daily ratio 76% (n = 19) do not attend health facilities. The results also show that 72.3% (n = 253) of them do not have health insurance (Table 3).

Table 3. Relationship between the Attendance of Health Facilities and the Perception of Health Facilities

Non-attendance of healthcare facilities			
Variables	**Modality**	**Frequency**	**(%)**
Why do you need to have an acquaintance in the Hospital	Care is faster	95	67,9
	Do not know	0(0)	0
	We do not pay	4	36,4

Lack of Confidence and the Presence of an Acquaintance

73.8% (n = 163) of non-attendants find that having a loved one or an acquaintance in the Hospital facilitates care (Table 4).

Lack of Confidence and Going to the Hospital only when the Illness is Severe

The results show that 74.2% (n = 175) of non-attendants go to health facilities only when the disease is severe (Table 4).

Table 4. Relationship between the Attendance of Health Facilities and the Perception of the Population Vis-à-vis Health Facilities and Disease

Non-attendance of healthcare facilities			
Variables	**Modality**	**Frequency**	**(%)**
Stage of gravity for hospital reference	Serious	175	74,2
	Not serious	87	64,0

*Significant variables

Discussion

The annual attendance rate of the health district of Mfou increased from 39% in 2015 to 42% in 2017. Despite this increase of 3%, it remains below the Togolese standard of 2013. However, our results are higher than those of Ikelle [4] on the attendance rate of health facilities in the health district of Bonassama in Douala (10% in 2002 and 13% in 2006).

There are disparities in evolution between the attendance rate of the health district of Mfou as a whole and those taken in a disaggregated way by health area. For example, in the KOMASSI health area (rural area), it decreased by 7% between 2016 (29%) and 2017 (22%). However, in the health area of Mfou (urban area), it has increased from 72% in 2015 to 91% in 2017. This could be explained by the fact that the health area of Mfou is in an urban zone. These results corroborate those of Fall and Seck [10], which show an attendance rate of 30% in rural areas and 50% in urban areas in African countries.

The results show that 76.3% of participants who do not attend health facilities are not satisfied with the reception in the latter. This is likely because the reception is the first link in the chain of care, it sets the tone, the first impression and can facilitate or complicate the rest of the relationship between the patient and the health facility.

According to Boutin-Mostefa [11] in the reception at the CHU Montpelier, the reception is described as a real showcase of the Hospital. These positions need to know how to apprehend any situation while knowing how to remain professional. These functions require relational skills and skills acquired during training. According to Lunjwire [12], in his study of the behavior of the population of Goma in the search for care, "Diarrhea case study", the professional quality of the staff, the good reception, and the reasonable waiting time are the main factors that motivate the choice of a care structure. The interviews also reveal that participants prefer to disengage from attending health facilities if the reception is not satisfactory:

«QUALITATITIVE PARTICIPANT 2»: « *There are really things that go beyond me in the Hospital, how can they ask money as soon as you reach. It's like there's someone in the market who checks to see if you have the money or not. When my brain knows that I will be welcome with money claims at the reception, while I am suffering, I tend to prefer to stay at home or otherwise run.*

«QUALITATITIVE PARTICIPANT 1»; *"I do not like the attitude of caregivers who put some before others without any justification. You finish paying for the consultation and it is as if you came to steal in the Hospital. All that makes you hesitate to go to the hospital*».

This study reveals that 75.8% of participants are unaware of the existence of a community health workers and do not know the hours of operation of health facilities 75.4%. This tells us that the agents' devotion to society has disappeared, which would explain the corruption and all that refers to it. Providers play a crucial role in the health system, especially because of their regular interactions with patients. The behaviour of the caregiver is influenced by many factors, including values, social norms, supervision, skills, knowledge,

and structural context [13]. There is, therefore, a real problem of communication between the health facilities and the population who feels isolated because a link in the communication chain is broken, which leads to a lack of information of the population on the availability or even the existence operational health services.

According to the WHO, poverty leads to a serious lack of utilization of health services [14].

Regarding affordability, the results reveal that 68.3% of participants do not attend health facilities because the cost of services and drugs are high. These results are consistent with those of Ruelle [15], who estimated after a study on the evaluation of the quality of care that the quality must make it possible to guarantee to each patient, the assortment of diagnostic and therapeutic acts, ensuring him the best result in line with the current state of medical science, at the lowest cost for the same result, at the least iatrogenic risk, for its greater satisfaction with procedures, results, and human contacts within the health system [15]. In addition, most participants having more than 5000 FCFA (LOCAL CURRENCY IN CAMEROON) 76% and less than 1000 FCFA (LOCAL CURRENCY IN CAMEROON); 75% daily ration do not attend health facilities. These results are consistent with those of Izandengera [16], which reveals that only 44% of participants with low purchasing power were in health facilities during an episode of illness. «QUALITATITIVE PARTICIPANT 1»; "But how, you yourself, how do you see it? That's it, money, when you do not have, they don't even look at you in the Hospital".

Indeed, this observation is the same as that made by Lavy and Quigley [17] and Dor and Van der Gaag [18], who concluded that income is the main determinant of health service utilization. High-income individuals prefer to go out of Mfou for treatment, believing that health provision in Mfou is very basic.

This study shows that 64% of non-attending participants think that one should always have a relative who works in the Hospital before thinking of going there, and 73.8% of them find that the presence of a relative in the health facility facilitates the care. It appears that the Hospital is hostile, care is expensive, access is difficult, and corruption is omnipresent. This is the spirit in which people find themselves when they evoke health facilities. Hence the interest of having an acquaintance will appease and facilitate the care. These results are corroborated by the sociologist Christian Guimelli [19], who wrote that social representations "cover all the beliefs, knowledge and opinions that are produced and shared by individuals in the same group, with respect to 'a given social object... their primary function is to interpret the reality which surrounds us on the one hand, by maintaining with it relations of symbolization and on the other hand by attributing meanings to it'. This is part of the Health Belief Model, which attributes beliefs and opinions to the ability to change patients' therapeutic route. These ideological anchors are obstacles to the good attendance of health facilities.

The perception of the value of alternative therapies and self-registration is crucial because 74.2% of participants go to health facilities when the illness seems severe. This supposes, therefore, another mode of management of the disease. Indeed, if it is a combination of traditional medicine and conventional medicine for some, for others, the traditional therapeutic protocol may lead to the exclusion of the initiative to visit health facilities. It is thus a question of a "congestion" or "schematization", as Patrick Charaudeau describes it in the dictionary of speech analysis [20]. The notion of schematization has the role of showing something to someone; more precisely, it is a discursive representation directed towards a recipient of what its author conceives or imagines of a certain reality. It's evident here that the value of traditional healers, illegal

health centers, and self-medication are higher as compared to conventional medicine. Indeed, this study found that 73.1% of non-attending participants believed that the disease is due to witchcraft and that sorcery would not be treated in the hospital 75.4%. It is, therefore, a psychic construct that is rooted in morals and is continually nourished by society. This corresponds to the very foundation of social and cultural representations, which according to Moscovici [21], was an organized and structured symbolic system. This system would constitute a framework of interpretation and categorization that serves as an anchor for giving meaning and directing human behavior.

The interviews revealed that all participants first evoke a spell when they are sick. According to them, witchcraft cannot be treated at the Hospital. However, some people think that by spells, medical pathologies can be transmitted. But again, when others think that despite having recovered healing with a conventional therapeutic protocol, one must always refer to a naturopath. Other authors note the strong action of self-medication on the attendance rate of health facilities. A study carried out in Chad by [22] on the socioeconomic study on the costs and accessibility of health care to the population shows that 61% of the population make use of health structures when they are sick, 20% go among traditional healers, and 19% use self-medication. In Guinea, studies show that unlike in Chad, where only 19% self-medicate, despite the proximity of healthcare structures, 59% of people living in rural areas use self-medication against 20% in an urban setting. This factor is considered to be at the root of the underutilization of healthcare services [23]. In 2011, on World AIDS Day, WHO banned self-medication and encouraged people to use health care services to promote better health. A study conducted in Senegal by Sadio and Diop [24] on the use and demand of health care has seen several factors that influence the use of health facilities, including the cost of care, insufficient income, and high attendance of natural medicine. “Of the 6,331 individuals in the rural health zone who reported being ill during the month prior to the surveyor’s visit, 50% did not seek timely care given the poverty, the modern health sector and tertiary public health institutions serve mainly the well-to-do rural population, and the majority of the population goes mainly to traditional healers.

Graine [25], referring to the theory of planned behaviour develops a conceptualization in three stages to justify the action of the individual. According to him, commitment to action is determined by attitudes, subjective norms, and perceived behavioural control. Attitudes reflect the extent to which the commitment to a particular behaviour is assessed positively or negatively by the subject. Here, it is evoked the perception of the possible: cost/benefit and the degree of importance. It is in the context of this study that people will not participate in immunization sessions or health education if they do not find a real benefit. They will not move anymore if it is to pay more than at the nearby marabout. «QUALITATITIVE PARTICIPANT 3»; “Yes, there are times I’m sick but when I see my wallet and I estimate how much I’m going to pay in the hospital I stay quietly at home, and I manage differently”. Subjective norms correspond to the assessment that individuals or groups important to the individual make of his behavior, that is, the social pressure perceived by the individual. Here the valuation of the cost/benefit is social. These norms are based on the beliefs of the individual concerning the expectations of the reference groups important for the subject (friends, family, neighbors, etc.). In the context of this study, this part is reserved for the perception of the population with regard to disease and health facilities as well as the use of alternative medicine and self-registration.

«QUALITATITIVE PARTICIPANT 1»: « *The judgment of others and their experiences influence my choices regarding health structures. “, «QUALITATITIVE*

PARTICIPANT 2»; "I am integrated in my locality, and I share the same influences as everyone with regard to the sanitary attendance. ", «QUALITATITIVE PARTICIPANT 3»; "I am strongly influenced by my community because I live in it. ».

What is shared by its populations are natural attitudes of recourse to auto-prescription and alternative medicine. Health facilities are challenged when they have already tried everything. This aspect is supported by behavioural control. It refers to the perceived ease or difficulty in performing the behaviour (the individual's perception of the feasibility of the behaviour). This control can be influenced by past experiences but also by anticipated obstacles. In the present study, we discussed the effect of following the crowd, it is well known that the individual who took in its specific context will always find it easier to do like everyone else, than to stand against the direction of the wind. The subject is motivated to act with his community in a dynamic way. This interaction is evoked by the theory of motivation as presented by [26].

Conclusion

The variation in the attendance rate of health facilities is related to the reception, motivation of health workers, affordability, and lack of trust vis-à-vis health facilities and the people who work there. The Cameroonian health sector is currently undermined by « docta », the trader of hope. Indeed, more than 70% of the population in the health district of Mfou considers not going in first resort to the hospitals when they are sick. They prefer to refer to their neighbour "docta": who is either a traditherapists, or even a health staff who makes health his small business, without any legitimacy. Communication for behavioral change is necessary to solve this problem. However, the funding of strategies at the Ministry of Public Health requires the support of the entire government, all departments, because health is not just the problem of one department. The resolution of this public health problem necessitates placing the patient, "the client," at the center of the health policy because without him the health facilities have no more reason to be. Education should no longer be a filter for attendance at health facilities. Integrated approaches should promote information that is audible and understandable to all. It will also be necessary to always remember that in Africa and Cameroon health care must integrate the support network of the patient, be able to reflect his cultural environment: "to be competitive".

Conflict of Interest

The authors declare that they have no competing interest.

Acknowledgements

We wish to express our gratitude to the Mfou health district's management team, the ethics committee, and all the participants and investigators.

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