Staff Attitude as Barrier to the Utilisation of University of Calabar Teaching Hospital for Obstetric Care

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ABSTRACT

Focus group discussions (FGD) to assess how the attitudes of hospital staff influence the utilisation of health facility for obstetric care at the teaching hospital (UCTH), Calabar, Nigeria, were conducted. The participants were women of childbearing age and men in two communities, as well as health staff at the teaching hospital. The aims were to establish community perception of attitudes of hospital staff and their influence on the utilisation of UCTH for obstetric care. Negative attitudes of hospital staff towards patients stood as a barrier to the utilisation of available obstetric care. Lack of incentives and inadequate materials to work with, as well as poor remuneration contributed to these negative attitudes. Provision of incentives to hospital staff, enhanced regular pay to workers, and regular workshops to train hospital staff are suggested as possible solutions to this problem. (*Afr J Reprod Health* 2000; 4[2]:69-73)

RÉSUMÉ

L'attitude du personnel comme obstacle à l'utilisation des soins obstétriques au Centre Hospitalier Universitaire de Calabar. L'étude s'est servie de la méthode de discussion en groupes cibles pour évaluer la manière dont l'attitude du personnel au Centre Hospitalier Universitaire de Calabar (CHUC) au Nigéria influence l'utilisation des facilitiés de santé pour les soins obstétriques. Comme participants, l'étude s'est servie des femmes encore en âge d'avoir des enfants, les hommes de deux communautés, ainsi que le personnel médical du Centre Hospitalier Universitaire de Calabar. Le but était d'établir la perception qu'a la communauté à l'égard des attitudes du personnel de l'hôpital et leurs influences sur l'utilisation des soins obstétriques de CHUC. Les attitudes négatives de la part du personnel de l'hôpital envers les patients constituent un obstacle à l'utilisation du soin obstétrique disponible. Ces attitudes négatives ont été attribuées au manque de primes, à l'insuffisance de matériaux de travail et aux bas salaires. L'étude suggère que les solutions possibles résident dans la stimulation du personnel, l'augementation et le paiement des salaires réguliers au cadre et dans l'organsisation des ateliers pour former le personnel de l'hôpital. (*Rev Afr Santé Reprod* 2000; 4[2]:69-73)

KEY WORDS: *Attitudes, hospital staff, utilisation, health facility, obstetric care, barrier*

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Introduction

Maternal and perinatal morbidity and mortality are still high in most developing countries, compared with the industrialised countries,[1] and they pose public health problems. Of the 580,000 women who die each year during childbirth, over 98 per cent are from the developing world.[2-4] For every maternal death, it is estimated that 10–15 other women suffer serious health consequences[3] including vesico-vaginal fistula. In many countries in Africa and south-west Asia, the likelihood of a child dying during the first week of life is so great that infants are often not counted as existing until they are at least one week old.[1] The reduction of maternal and perinatal mortality remains a major goal of both the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) as part of the strategy of Health for All and the Child Survival and Development Revolution. This has been attempted by bolstering prenatal care to recognise complications, facilities to treat them, accessible obstetric care and family planning advice to prevent mistimed and unwanted pregnancies.[5]

Recently, it was reported from Saudi Arabia that utilisation of the little available emergency obstetric care is on the decline.[6] This is similar to observations at the University of Calabar Teaching Hospital. Various authors have already advanced many reasons for the poor utilisation of modern health facilities. Such reasons include distance, poor transport and communication facilities, lack of formal education and high cost of services.[7-12] Other reasons given include lack of husband's permission,[13] religious reasons,[14] routine episiotomy for vaginal delivery[15] and the negative attitude of hospital staff towards patients. The establishment of a government-owned general hospital in Calabar and a relatively higher hospital bill at the UCTH have already been noted also as contributing factors. A defaulting rate of 47.8% at the UCTH antenatal clinic has been reported.[16] There are yet no published reports on the influence of negative attitudes of hospital staff on the utilisation of orthodox health facilities for delivery by women. Hence, this survey was conducted to establish community perception of the attitudes of hospital staff and their influence on utilisation of health facilities for both delivery and emergency obstetric care.

Study Population and Research Methodology

Focus group discussion (FGD) was used in this study because it allows the people affected to express their feelings directly and in their local language. FGDs also allow in-depth probe of the people's perception. Two communities within which the main referral centres to the University of Calabar Teaching Hospital are located were chosen. These are Ikot Omin and Ikot Ene.

Ikot Omin

Ikot Omin is located within Calabar municipality and it is about 15km from the University of Calabar Teaching Hospital. It consists of three major villages, Ikot Effanga Mkpa, Ikot Ekpo and Ikot Omin proper, and other smaller settlements. In 1983, it had an estimated population of 22,151 with a total female population of 11,172, out of which 2,929 are women of childbearing age (15–49 years).[17] The natives are mainly Efik, Qua and a few Hausa nomads. Majority are Christians while the Hausa nomads are mainly Moslems. There is a health centre in the community. Their major occupations are farming and trading. The Calabar-Ikom highway runs through the community, although there are several other roads within.

Ikot Ene

Ikot Ene is in Akpabuyo Local Government Area, about 35 kilometers from the University of Calabar Teaching Hospital. It comprises five villages (Ikot Ene proper, Ababot Eneyo, Ikot Offiong Ambai, Ikot Edem Odo and Ikot Nakanda), and a few other settlements on its fringes. The estimated population is 16,475, out of which 8,310 are females. Women of childbearing age are about 2,179.[17] They are mainly the Efiks, Ibiobios and Annangs. The Calabar-Ikang road links the community with Calabar municipality. However, there are other roads within the community. There is a cottage hospital and two health centres in this community.

Focus Group Discussion

The *Design and Evaluation of Maternal Mortality Programs*[18], a manual published by the Centre for Population and Family Health was used as a guide for the discussions. Each focus group consisted of

between six and ten participants, a facilitator, a tape recorder and a note-taker. The discussions took place in the evening, between 4.00 and 7.00 p.m. Nigerian time, as this is the time the participants usually come back from markets and farms. The venue was the village schools, under the trees and in town halls. Efik, the local language, and pidgin English were the languages used for communication. Each focus group session lasted for between one and two hours.

A total of twenty focus group sessions were conducted; nine sessions with women in Ikot Ene, eight with women in Ikot Omin, one with men in each of the two communities and one with the hospital staff. The hospital staff consisted of resident doctors, practicing midwives and ward orderlies. The women were chosen based on the following classification: the educated low parity; the educated high parity; the uneducated low parity; and the uneducated high parity. This method of classification allowed the women to fall into their different age groups as much as possible. The parameters used in the grouping are also factors that can influence human perception of the attitudes.

The men involved in this study were the husbands of some of these women and they were elders in their communities. They are also the ones that take decisions concerning women, as affirmed by both the women and men groups during the FGDs.

Definition of Terms

1. The *educated* were women who had read up to standard six (after years in elementary school) and above and they could read and write.
2. The *uneducated* were women who had no formal education.
3. The *high parity* were women who had had five or more deliveries.
4. The *low parity* were women who had had four or less deliveries.
5. *Prolonged labour* was taken as labour that lasted longer than sunrise-to-sunrise or sunset-to-sunset.

Results

Women's Perception of Staff Attitude

Majority of women in the four groups in the two communities abhorred the attitude of hospital staff towards patients. The uneducated high parity women reported that most of them visit traditional birth attendants (TBAs) and spiritual churches first when complications like haemorrhage, eclamptic fit and prolonged labour arise, and would only go to the hospital when all unorthodox attempts at delivery have failed.

A large number of women reported that sometimes doctors and nurses on duty would not be found. Instead of going to die in the hospital, they prefer to die at home.

> *Where the nurses on duty are seen, they show no sympathy but rather throw abuses at the women.*

They accused the hospital staff of uttering such statements as:

> *... Madam I did not send you o! If you like push your baby, if you do not like, lie down there.*

> *Doctors and nurses only pay attention to their friends and relatives or those "who have seen them privately" (The few privileged rich ones).*

Most of them affirmed that even ward orderlies shout at and scold them especially when a woman is in active labour, helpless and cannot walk around to throw orange peels into the dust bin.

> *Some of them lock toilets and tell us, "I am not a night-soil-man...there is no water to flush your big shits."*

Most times, there is no ambulance. When there is one, the driver feels he needs some sleep, as one of them put it:

> *... is driver not a human being? I beg - O, me I go sleep for even fifteen minutes, make I no go jam rock and die for this una call. How much I dey earn sef.*

The records clerks need little tips to retrieve a patient's folder, otherwise they become very rude or "go to the bank" and leave patients on the chairs.

Men's Views of the Problem

The men interviewed from the two communities believe that women should always go to hospital when labour starts. Most of the time money would be made available and transportation provided but the women prefer TBAs or the churches. This is unlike what used to happen few years ago. They usually complain of abuses from the nurses, that they might be neglected, and that even when they are about to deliver no one comes around to give the needed care.

> *We men are at times embarrassed by the action of nurses. They would not allow you get close to your wife. Where you attempt, they would shout, "...oga go out - O, other women are here, not your wife alone".*

Hospital Staff's Evaluation of the Problem

The hospital staff agreed that their attitudes were most of the time negative. They ascribed this to the fact that women usually come too late to the hospital. For example, those booked for elective caesarian section would not come until after many hours in labour at home. Many of them would usually arrive without any funds to procure the required consumables.

Many a times there may be nothing available to work with in the hospital, even water and electricity may not be available. The doctors feel the worst place is the theatre, where you may find nothing there. Drapes may not be available. Patients for caesarian section are usually given a long shopping list even a night before an emergency caesarian section is to be done. The doctors find the job most frustrating and there is no job satisfaction, coupled with their paltry monthly wages.

Discussion

This FGD study shows that the negative attitude of hospital staff towards patients is a barrier to the utilisation of orthodox health facilities for obstetric care in Calabar. This is similar to reports by Abu-Zeid and Dann,[18] from their study of health service utilisation and cost in Ismailia, Egypt. They found that 13 of 29 households did not utilise available health services, as they were dissatisfied with the attitude of the hospital staff. The gravity of this can only be appreciated when we realise that most obstetric complications, which can be treated by providing emergency obstetric care, cannot be predicted.[5] Anything that prevents women from utilising available obstetric care spells danger to the lives of expectant mothers and their babies. A woman having primary postpartum haemorrhage in the hospital, for example, stands a better chance of surviving than one who is bleeding at home. To stem this carnage, there is need for government to provide incentives, with enhanced and regular pay to health workers, as this will make them to be happy and more dedicated to duty. This implies that a policy of an exclusive salary scale and welfare package for health workers that is attractive will be a welcome development.

The hospital authority should plan regular workshops to highlight the effects of the negative attitude of hospital staff on health services utilisation. Reducing pregnancy-related mortality and morbidity involves not only making sure that all women have access to quality antepartum and intrapartum care, but also ensuring that the various groups of people whose action or inaction can make the difference between life and death know what role they have to play in making motherhood safe.[19] There is need to provide sleeping-in facilities for doctors to enable them to offer 24-hour service in the maternity unit of the hospital. There should be regular supply of water, electricity and other materials to work with.

The community, health workers at primary and secondary levels of care, as well as TBAs need to be educated on the fatal nature of obstetric complications such as haemorrhage, sepsis, pre-eclampsia and eclampsia. Hence the importance of utilising available emergency obstetric care in spite of the behaviour of hospital staff. Where a hospital staff is found to be unruly, he/she should be severely punished, to serve as deterrent to other health staff.

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