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POVERTY AND PATIENT ABANDONMENT IN THE UNIVERSITY OF CALABAR TEACHING HOSPITAL (UCHTH), NIGERIA.

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ABSTRACT

This paper assesses the relationship between poverty and patient abandonment and its effect on health care services in the University of Calabar Teaching Hospital, Calabar, Nigeria. A survey design was adopted, data were collected through questionnaires and interviews, including secondary data from the hospital records. A total of 100 respondents which were stratified into hospital workers and patients were used for the research. Field data confirmed that cultural interpretation and perception of poverty bordered on economic and welfare dimensions and that there is a significant relationship between poverty and patient abandonment. Patient's abandonment was generally condemned and described variously as a demonstration of wickedness, wretchedness and ungodliness by respondents. Such behaviour deleteriously affected health care services as stringent measures are often evolved by hospital management which further frustrates admission of indigent patients into the wards for treatment. Although the public generally believes that government should subsidize or offer free medical treatment to Nigerians, the research finding has confirmed that such perception has no relationship with patient abandonment.

KEY WORDS: Poverty, Patient Abandonment , Health care, Culture, Illness.

INTRODUCTION

Poverty is not simply a matter of physical and material deprivation but a much more complex social phenomenon with economic, cultural and socio-political dimensions (Cooksey, 1997:93). It is a potential and crucial determinant of social behaviour including patient abandonment in hospitals. Which is why Lugalla (1997: 146 – 152) approaches poverty from a situation or condition of living that is insufficient in maintaining minimal necessities of life like food, housing, safe water, protection from diseases and ignorance.

Poverty, therefore, is a social relation and its creation, persistence and maintenance involves a variety of social processes. In other words, the situation of poverty can only be analyzed within the context of the relationships of socio-economic inequality, exploitation and subordination. To this extent, identifying the poor in a specific country or society depends much not only on global indices of poverty such as food security index or basic needs index or a set of numbers (Oyen 1996), but also on cultural interpretation of poverty (Charles: 2001). The poor and the wealthy or the underprivileged and privileged are all culture bearers. The underprivileged is so categorized in comparison to the privileged within the same community or society. The global tone of poverty may not really give an understanding of societal or community poverty even if economic indices such as per capita income or basic purchasing power were used.

This explains why Galbraith (1969: 286) held the opinion that people are poverty-stricken when their resources fall radically behind that of the community and are therefore so judgementally defined as poor by the community. The minimum or maximum limits of wealth or poverty are determined by the community. Be it as it may, the poor is not too difficult to identify within any community. They are those whose basic needs are not adequately met, those who earn inadequate income, live in squalid environment and can therefore not support themselves both in times of illness and health.

STATEMENT OF THE PROBLEM

Good health is a cherished state. To look healthy is an achievement which brings joy and happiness to both the individual and his relations or friends. This concern about health is re-echoed customarily each time we meet a close friend, a relation and more so, a person we have not seen for a long time. That is why Richman (1987) has pointed out that African greetings seem to probe more into our well-being or state of health. This may not really be restricted to Africans alone, as all races of the world are

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mindful of the health of those around them. Such greetings as "how is everything", "how do you do?" "and how is your health?" convey deep concern for the health of interacting persons across people of the world.

Africans know more than anything else that "to be healthy means more than not having a disease or infirmity" (Jegede, 1998: 24) and that health represents almost a perfect or equilibrium state of being. To be sick, therefore, conveys imagery of physical, mental, economic and social dysfunctioning which must be combated through appropriate health seeking behaviour.

The health seeking behaviour of an African is often times not determined by the sick person himself but by opinion leaders in his social network. These opinion leaders, sometimes, are the parents, uncles, close friends or other significant others in the extended family network. They are the ones who would suggest alternative modes of treatment so that the person might be relieved of his illness. Although it is often taken for granted that increased information dissemination has also positively affected popular preference for and increase in the use of modern health care services (Orubuloye and Caldwell 1992; Ikenne 1993 and Jegede: 1996), it must be appreciated that inspite of such awareness and utilization of modern health facilities, Africans are yet to divorce their primordial and primary kinship affiliation from the demands of a westernized setting of a hospital where patients and health workers interact in a more informal atmosphere. This may then explain why a social scientist or social worker, to be very specific, becomes an important agent in reassuring the patient and re-establishing the cherished familial environment for the patient in the hospital on admission.

The role of such a social scientist has been acknowledged in the sense that many diseases have socio-economic, demographic and environmental bases, and so their transmission and spread are also aided by these factors (Lambo; 1984: 88). The role of the social scientist would, inter alia, be to identify socio-economic and cultural factors affecting patients in orthodox medical market place, such as the hospital. This demand becomes urgent and crucial because cities and towns in Africa are natural abode for the few rich and majority poor, jobless and unskilled among whom dire poverty and deprivation prevail. The increase in influx of people into urban centers makes living conditions to deteriorate and uncomfortable. Health facilities are over-stretched and health care services become exorbitant and therefore not within the reach of the less-privileged and the poor, resulting ultimately in patient abandonment in the hospitals. For instance, existing records, spanning 1990 – 2000 have shown that a total of 354 patients have been abandoned in UCTH, leaving behind huge bills and the burden of repatriation of these patients by the hospital management. This study which culminated in this paper was aimed at considering the relationship between poverty and patient abandonment in the University of Calabar Teaching Hospital. It sought to address whether patient abandonment is a way of life that must be transmitted to the younger generation as a rational reaction to health seeking behaviour, to examine how poverty and patient abandonment are perceived culturally and to assess the contribution of socio-cultural factors to poverty and patient abandonment.

RESEARCH DESIGN AND METHODOLOGY

The researchers adopted a survey research design. The survey data were collected through questionnaire and interviews administered on patients, doctors, nurses, administrators and social workers in the University of Calabar Teaching Hospital, Calabar. The questionnaires were administered in the Maternity Annex of the hospital.

Simple random sampling method was used to select doctors, nurses, administrators and medical social workers while systematic random sampling method was used to select patients and patient relations in the wards for the study. Using systematic random sampling method, it was possible to select a patient at the entrance of the ward and every third patient or patients' relations for interview. Where the lot fell on the patient who could not speak or write because of health, a relation was picked as a replacement. In all, 60 patients/relations were in the sample, while 10 each of the nurses, doctors, administrators and social workers made up the remaining sample.

Out of the 60 patient/relation respondents, 30 were literate enough to fill in the questionnaire while another 30 were semi or non-literate and were interviewed using the same research instrument. The difference was that the literate respondents wrote down their responses to the various questions while a research assistant asked the questions and wrote down responses for the non-literate or semi-literate patients.

The questions were open and closed-ended depending on information required, and was aimed at eliciting information on socio-demographic and other substantive issues aimed

Table 1: Demographic Description of Respondents

	Hospital Workers				Patients				Total	
	Administrator		Health Workers		Literate		Non-Literate			
	N = 30	(%)	N = 30	(%)	N = 30	(%)	N = 30	(%)		(%)
Age										
10 - 20	-	-	-	(-)	4	(4.00)	4	(4.00)	8	(8.00)
21 - 30	3	(3.00)	3	(3.00)	13	(13.00)	11	(11.00)	30	(30.00)
31 - 40	6	(6.00)	15	(15.00)	10	(10.00)	7	(7.00)	38	(38.00)
41 - 50	1	(1.00)	10	(10.00)	1	(1.00)	8	(8.00)	20	(20.00)
51+	-	(-)	2	(2.00)	2	(2.00)	-	-	4	(4.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
Sex										
Male	5	(5.00)	12	(12.00)	17	(17.00)	16	(16.00)	50	50.00
Female	5	(5.00)	18	(18.00)	13	(13.00)	14	(14.00)	50	50.00
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
Educational Qualification										
Primary	-	(-)	1	(1.00)	-	-	30	(30.00)	31	(31.00)
Secondary	1	(1.00)	1	(1.00)	13	(13.00)	-	-	15	(15.00)
NEC/Nursing	1	1.00)	3	(3.00)	9	(9.00)	-	-	13	(13.00)
University	8	(8.00)	25	(25.00)	8	(8.00)	-	-	41	(41.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
Occupational Distribution										
Civil Servant	10	(10.00)	30	(30.00)	20	(20.00)	17	(17.00)	77	(77.00)
Business	-	-	-	-	3	(3.00)	5	(5.00)	8	(8.00)
Applicant	-	-	-	-	6	(6.00)	8	(8.00)	14	(14.00)
Student	-	-	-	-	1	(1.00)	-	-	1	(1.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
Monthly Income Distribution										
Below N5,000	-	-	-	-	4	(4.00)	3	(3.00)	7	(7.00)
N5001 – 10,000	2	(2.00)	-	-	3	(3.00)	4	(4.00)	9	(9.00)
N10,001-15,000	-	-	1	(1.00)	8	(8.00)	8	(8.00)	17	(17.00)
N15,001-20,000	2	(2.00)	2	(2.00)	3	(3.00)	2	(2.00)	9	(9.00)
N20,001-25,000	2	(2.00)	2	(2.00)	5	(5.00)	2	(2.00)	11	(11.00)
N25,001-30,000	-	-	1	(1.00)	3	(3.00)	3	(3.00)	7	(7.00)
N30,001-35,000	2	(2.00)	6	(6.00)	3	(3.00)	2	(2.00)	13	(13.00)
N35,001-40,000	-	-	2	(2.00)	1	(1.00)	3	(3.00)	6	(6.00)
N40,001+	2	(2.00)	16	(16.00)	-	-	3	(3.00)	21	(21.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
Ethnic Group										
Northern	-	-	-	-	1	(1.00)	1	(1.00)	2	(2.00)
Western	-	-	-	-	2	(2.00)	3	(3.00)	5	(5.00)
Eastern	2	(2.00)	5	(5.00)	4	(4.00)	2	(2.00)	13	(13.00)
South Eastern	8	(8.00)	25	(25.00)	23	(23.00)	24	(24.00)	80	(80.00)
Middle Belt	-	-	-	-	-	-	-	-	-	-
Mid-Western	-	-	-	-	-	-	-	-	-	-
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	30	(30.00)
Marital Status										
Never Married	1	(1.00)	8	(8.00)	15	(15.00)	9	(9.00	33	(33.00)
Married	9	(9.00)	19	(19.00)	15	(15.00)	20	(20.00)	63	(63.00)
Divorced	-	-	2	(2.00)	-	-	1	(1.00)	3	(3.00)
Widowed	-	-	1	(1.00)	-	-	-	-	1	(1.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	30	(30.00)
No. of Children by Respondents										
None	1	(1.00)	6	(6.00)	13	(13.00)	11	(11.00)	31	(31.00)
1 – 2	4	(4.00)	12	(12.00)	11	(11.00)	5	(5.00)	32	(32.00)
3 – 4	4	(4.00)	10	(10.00)	2	(2.00)	10	(10.00)	26	(26.00)
5 – 6	1	(1.00)	1	(1.00)	4	(4.00)	3	(3.00)	9	(9.00)
7+	-	-	1	(1.00)	-	-	1	(1.00)	2	(2.00)
Total	10	(10.00)	10	(30.00)	30	(30.00)	30	(30.00)	30	(30.00

at answering the research questions. In addition, secondary data were collected on a ten-year bio-statistics of cases of patients abandoned since 1990 – 2000.

DATA PRESENTATION AND ANALYSIS

For the purposes of analysis, respondents were further categorized into Hospital Workers and Patients. Hospital workers included Administrators, Doctors, nurses and Medical Social Workers; these were further classified into administrators and health workers. All the responses were expressed as simple percentages of the total responses in the various responses respectively.

(a) General Description of Demographic Data:

From the data in Table 1 above, the age of respondents ranged from 10 to 50+ years. Those aged 10 to 20 years totalled 8(8.00%), 21 – 30 years were 30(30.00%) and those aged 31 – 40 years were 38(38.00%). The respondents aged 41 – 50 years and 50+ years totalled 20(20.00%) and 4(4.00%) respectively. Sex distribution of the respondents was even as males were 50(50.00%) and females 50(50.00%).

Educationally, 41(41.00%) of the respondents held university degrees, 13(13.00%) were OND/NEC/Nursing graduates while 15(15.00%) and 31(31.00%) respectively attained secondary and primary education. From the data also 77(77.00%) of the respondents were civil servants while 8(8.00%), 14(14.00%) and 1(1.00%) were business people, applicants and students respectively.

Monthly income distribution showed that 21(21.00%) earned N40.001+, 6(6.00%) earned N35,001 – N40,000 and 13(13.00%) received N30.001 – N35,000. A total of 7(7.00%), 11(11.00%) and 9(9.00%) earned N25,001 – N30,000, N20,001 – N25,000 and N15,001 – N20,000 respectively. The number whose monthly income stood at below N5,000, N5001 – N10,000 and N10,001 – N15,000 numbered 7(7.00%), 9(9.00%) and 17(17.00%) respectively.

From table 1 also, marital status of the respondents indicated that 33(33.00%) were "never married", 63(63.00%) were married while 3(3.00%) and 1(1.00%) respectively were divorced and widowed. Out of the total number of respondents, 31(31.00%) and 32(32.00%) respectively had no children and 1 –2 children, while 26(26.00%) had 3 – 4 children, 9(9.00%) got 5 – 6 children and 2(2.00%) had 7+ children.

SPONSORSHIP OF PATIENTS IN THE HOSPITAL

It was necessary to know whether any of the respondents had ever sponsored or taken anybody to the hospital before and their relationship with such people. To elicit this information, two questions which read "Have you ever taken or sponsored anybody to the hospital for treatment?, and "How related are these persons to you?" respectively attracted the following responses.

Table 2 shows that a total of 91(91.00%) respondents had ever taken or sponsored patients to the hospital and only 9(9.00%) had

Table 2: Sponsorship of Patients to Hospital and Relationship with Patients

	Hospital Workers				Patients				Total	
	Administrator		Health Workers		Literate		Non-Literate			
	N = 30	(%)	N = 30	(%)	N = 30	(%)	N = 30	(%)		(%)
(i) Ever sponsored Patients to Hospital:										
Yes	9	(9.00)	28	(28.00)	28	(28.00)	26	(26.00)	91	(91.00)
No	1	(1.00)	2	(2.00)	2	(2.00)	4	(4.00)	9	(9.00)
Total	10	(10.00)	30	(30.00)	30	(30.00)	30	(30.00)	100	(100.00)
(ii) Relationship to Patient:										
Child	5	(2.34)	21	(9.81)	7	(3.27)	15	(7.01)	48	(22.43)
Husband/Wife	3	(1.40)	12	(5.61)	10	(4.67)	10	(4.67)	35	(16.36)
Parents	4	(1.87)	18	(8.41)	13	(6.07)	12	(5.61)	47	(21.96)
Cousin/Neighbour	0	(-)	16	(7.48)	9	(4.21)	11	(5.14)	36	(16.82)
Distant Relation	2	(0.94)	14	(6.54)	5	(2.34)	6	(2.80)	27	(12.62)
House Maids/ Domestic Servant	1	(0.47)	11	(5.15)	1	(0.47)	8	(3.74)	21	(9.81)
Total	15	(7.02)	92	(42.99)	45	(21.03)	62	(28.99)	214*	(100.00)

*Due to multiple options.

never done so. Out of the 214 responses from the multiple choices, 48(42.43%) were children of the respondents, 35(16.36%) were husbands or wives while cousins or neighbours made up 36(16.82%). Distant relations were 27(12.62%), parents 47(21.96%) and housemaids 21(9.81%).

CULTURAL INTERPRETATION/MEANING OF POVERTY AND PATIENT ABANDONMENT

In order to gauze cultural interpretation of poverty and the act of patient abandonment, the following questions were posed to the respondents, viz, "In your ethnic group, what conditions must be present in order to classify a person as poor?"; and "what cultural interpretation could be given to people who abandon their patients?" Table 3 elicits these responses as follows from the various ethnic groups from the Northern, Western, Eastern and south Western Nigeria which made up the sample.

From Table 3, a total of 31(12.92%) respondents said poverty meant "lack of shelter/accommodation." 48(20.00%) mentioned "lack of sources of livelihood", while 14(5.83%) indicated that poverty was synonymous with "prolonged ill-health". To 25 (10.42%) respondents, poverty was indicated by "tattered dressing", while 13(5.42%) were of the opinion that "lack of relations/kinsmen "was one of the indicators of poverty. A total of 51(21.25%) mentioned "lack of money" and 5(2.09%) said poverty was indicated by "lack of farm land". Other indicators mentioned as cultural interpretation to poverty were "lack of food" 41(17.08%), "ignorance" 6(2.50%), and "lack of basic necessities", 6(2.50%).

Different cultural meanings/interpretations were also given to the act of abandoning patients. A total of 67 (23.68%) said the act was "ungodly", 65 (22.97%) were of the opinion that it was an expression of "wickedness", while 57(20.14%) indicated that patient abandonment was act of "wretchedness". About 53(18.78%) described the act as "dubiousness", and 32(11.30%) were of the opinion that such people were "cursed", while 6(2.12%) and 3(1.06%) said such people were just "smart" and "clever" respectively.

REASONS FOR PATIENT ABANDONMENT

When asked specifically why people abandon patients after admission into the hospital, 90(90.00%) of the respondents agreed that poverty was the main reason for such a behaviour. However, when respondents were

Table 3: Cultural Meaning/Interpretation of Poverty and Patient Abandonment

Cultural Interpretation	Hospital Workers				Patients				Total	
	Administrator		Health Workers		Literate		Non-Literate			
	N = 30	(%)	N = 30	(%)	N = 30	(%)	N = 30	(%)		(%)
Cultural Interpretation of Poverty										
i) Lack of shelter/ accommodation	5	(2.08)	8	(3.33)	7	(2.92)	11	(4.58)	31	(12.92)
ii) Lack of sources of livelihood	6	(2.50)	14	(5.83)	17	(7.08)	11	(4.58)	48	(20.00)
iii) Prolonged ill-health	2	(0.83)	2	(0.83)	6	(2.50)	4	(1.67)	14	(5.83)
iv) Tattered dressing	3	(1.25)	8	(3.33)	6	(2.50)	8	(3.33)	25	(10.42)
v) Lack of Relation/ Kinsmen	1	(0.42)	6	(2.50)	2	(0.83)	4	(1.67)	13	(5.42)
vi) Lack of money	5	(2.08)	14	(5.83)	16	(6.67)	16	(6.67)	51	(21.25)
vii) Lack of farmland	2	(0.83)	-		-	-	3	(1.25)	5	(2.08)
viii) Lack of food	2	(0.83)	17	(7.08)	13	(5.42)	9	(3.75)	41	(17.08)
ix) Ignorance	1	(0.42)	2	(0.83)	2	(0.83)	1	(0.42)	6	(2.50)
x) Lack of Basic Necessities	2	(0.83)	2	(0.83)	-	-	2	(0.83)	6	(2.50)
Total	29	(12.07)	73	(30.39)	69	(28.75)	69	)28.75)	240	(100.00)
Cultural interpretation of Patient Abandonment :										
i) Cleverness	-	-	-	-	-	-	3	(1.06)	3	(1.06)
ii) Smartness	1	(0.35)	1	(0.35)	2	(0.71)	2	(0.71)	6	(2.12)
iii) Dubiousness	5	(1.77)	10	(3.53)	18	(6.36)	20	(7.07)	53	(18.73)
iv) Wickedness	4	(1.41)	21	(7.42)	23	(8.13)	17	(6.01)	65	(22.97)
v) Accursed	2	(0.71)	4	(1.41)	13	(4.59)	13	(4.59)	32	(11.30)
vi) Wretchedness	5	(1.77)	17	(6.01)	17	(6.01)	18	(6.36)	57	(20.14)
vii) Ungodly	3	(1.06)	18	(6.36)	25	(8.83)	21	(7.42)	67	(23.68)
Total	20	(7.07)	71	(25.08)	98	(34.63)	94	(33.22)	283*	(100.00)

*Due to multiple options

Table 4: Reasons for Patient Abandonment

Reasons for Patient Abandonment	Hospital Workers				Patients				Total	
	Administrator		Health Workers		Literate		Non-Literate			
	N = 30	(%)	N = 30	(%)	N = 30	(%)	N = 30	(%)		(%)
Lack of Money	10	(2.97)	27	(8.01)	23	(6.83)	26	(7.71)	86	(25.52)
High cost of Medical treatment	8	(2.37)	27	(8.01)	24	(7.12)	26	(7.71)	85	(25.22)
Severity of Sickness	4	(1.19)	19	(5.64)	10	(2.97)	11	(3.26)	44	(13.06)
Long Distance	1	(0.30)	12	(3.56)	9	(2.67)	10	(2.97)	32	(9.50)
No Sleeping facilities	4	(1.19)	10	(2.97)	8	(2.37)	10	(2.97)	32	(9.50)
Too many tests	2	(0.59)	7	(2.08)	7	(2.08)	8	(2.37)	24	(7.12)
High handedness of doctors/nurses	3	(0.89)	4	(1.19)	3	(0.89)	7	(2.08)	17	(5.05)
No Blood Relations	2	(0.59)	6	(1.78)	2	(0.59)	0	-	10	(2.96)
Hospital workers' Advice	0	-	2	(0.59)	1	(0.30)	2	(0.59)	5	(1.48)
Ignorance	0	-	1	(0.30)	1	(0.30)	0	-	2	(0.60)
Total*	34	(10.09)	115	(34.13)	88	(26.12)	100	(29.67)	337*	(100.00)

*Multiple choice

Table 5: Effects of Patient Abandonment on Health Care Delivery

Effective of Patient Abandonment	Hospital Workers				Patients				Total	
	Administrator		Health Workers		Literate		Non-Literate			
	N = 10	(%)	N = 30	(%)	N = 30	(%)	N = 30	(%)		(%)
Emphasis on Deposit	9	(2.20)	26	(6.36)	16	(3.91)	21	(3.91)	72	(17.60)
Rigid condition for Admission	7	(1.71)	23	(5.62)	19	(4.65)	16	(3.62)	65	(15.89)
Patients Die on Admission	6	(1.47)	15	(3.67)	16	(3.91)	23	(5.62)	60	(14.67)
Increased Suspicion	6	(1.47)	19	(4.65)	14	(3.42)	19	(4.65)	58	(14.18)
Patients forced to buy Drugs	3	(0.73)	15	(3.67)	16	(3.91)	10	(2.45)	44	(10.76)
Shortage of Bed space	4	(0.98)	16	(3.91)	7	(1.71)	12	(2.93)	39	(9.54)
Doctors/Nurses can't apply their skills	3	(0.73)	11	(2.69)	9	(2.20)	9	(2.20)	32	(7.82)
Hospital can't break even	2	(0.49)	13	(3.18)	7	(1.71)	5	(1.33)	27	(6.60)
Hospital staff are not paid	-	-	3	(0.73)	7	(1.71)	2	(0.49)	12	(2.93)
Total	40	(9.78)	141	(34.48)	111	(27.13)	117	(28.60)	409*	(99.99)

*Multiple Choice

required to specify other specific reasons, the following responses were mentioned concerning factors such as "lack of money" 86(25.52%), "High cost of treatment" 85(25.22%), "severity of sickness" 44(13.06%) and others as shown in Table 4.

EFFECTS OF PATIENT ABANDONMENT

Effects of patient abandonment on health care delivery were obtained from the respondents and their responses were tabulated in Table 5. For instance, 65(15.89%) of the respondents were of the opinion that patient abandonment leads to rigid conditions for admission into the hospital, 72(17.60%) were more specific when they mentioned that such an act leads to "emphasis on payment of deposit" before a patient is admitted while 60 (14.67%) and 58(14.18%) respectively said that patient abandonment causes "patients to die" on admission and also leads to "increase suspicion" between patient/patient relations on

the one hand and hospital workers on the other. "Shortage of bed space" was mentioned by 39(9.53%) and 44(10.79%) said "patients are forced to buy drugs" before treatment is given. Table 5 below gives the responses.

ABANDONED PATIENTS BY YEAR

Official statistics showed that a total of 354 patients were abandoned between 1990 and 2000 at the University Teaching Hospital, Calabar. In 1990 a total of 71(20.06%) patients were abandoned, in 1991 another 55(15.54%) were abandoned while in1992, 1993, 1994 and 1995, 36(10.17%), 29(8.19%), 32(9.04%) and 39(11.02%) respectively were abandoned. The number abandoned in 1996, 1997, 1998, 1999 and 2000 respectively were 19(5.37%), 17(4.80%), 24(6.78%) 18(5.08% and 14(3.95%). Table 6 represents the data as discussed.

DISCUSSION

Patient's abandonment was highest in 1990 with 71(20.00%) of abandoned cases. Although there appeared to be a progressive decrease to 29(8.19%) in 1993, an increase was again noticed from 32(9.04%) to 39(11.02%) in 1994 and 1995 respectively. Another increase was noticed in1998 when the number of abandoned patients rose to 24(6.78%). All the years between 1990 – 1998 represented an era of military rule in Nigeria where the economy of the country was adversely affected by series of sanctions from United Nations and the Commonwealth organizations.

These sanctions negatively affected the purchasing power of an average Nigerian. There was a high rate of unemployment as well as the prevalence of starvation wages in government establishments, which remained a major employer of labour in the country. It may be too early, however, to assess the phenomenon of patient abandonment in the democratic dispensation but the data seem to show a gradual decrease to 18(5.08%) in 1999 and 14(3.95%) in 2000. This may not be unconnected with the general salary increase in1999 which shot the minimum wage from a miserable N750 per month to N7,500 and N6,500 per month respectively for federal and state government workers.

Occupational distribution of the patients showed that majority of the patients, that is 61.67% of them (illiterate and non-literate) were civil servants who earned a salary of between ₦5,000 – N40,000+ monthly. It should also be noted that out of the sixty patients' relations about 33.33% of them had 3 – 7+ children and 54(90.00%) of them had sponsored patients to the hospital before. A total of 67(62.61%) of these patients sponsored were their children, husbands/wives and parents, while 40(37.38%) were relations, neighbours and domestic hands. This seems to demonstrate that although Africans are often seen as their brothers' keepers, in health care expenses, more is often spent on immediate relations such as children, husbands/wives and parents than distant relations. This tendency is shown more by the educated respondents than by the non-literate ones. This may account for a total of 36(16.82%) responses which represented distant relations such as cousins/neighbours sponsored to the hospital. However, health workers tended to sponsor many other relations other than the immediate relations.

For instance, out of a total of ninety two responses by the health workers, 51(54.43%) out of 92(100.00%) of those sponsored to the hospital were immediate relations and

Table 6: Abandoned Patients of Year

YEAR	NO. OF PATIENT	(%)	CUMULATIVE	TOTAL (%)
1990	71	(20.06)	71	(20.06)
1991	55	(15.54)	126	(35.59)
1992	36	(10.17)	162	(45.76)
1993	29	(8.19)	191	(53.95)
1994	32	(9.04)	223	(62.99)
1995	39	(11.02)	262	(74.01)
1996	19	(5.37)	281	(79.38)
1997	17	(4.80)	298	(84.18)
1998	24	(6.78)	322	(90.96)
1999	18	(5.08)	340	(96.04)
2000	14	(3.95)	354	100

41(44.57%) were other relations. This difference between health workers and other literate respondents could be explained by the humanitarian nature of their profession and the value they attach to the good health of those around them irrespective of the type of relationship existing between them and the sick person. It has been demonstrated that "there is close identification of kin group with the sick person from the onset of illness since the kin group takes decision about treatment and participate in it" and that "the members obligation and preparedness to assist are the measures of their perception of danger to the whole group (Jegede; 1996:71). Health workers showed more understanding of perceived danger hence their inclination to sponsor more people other than immediate relations to hospital.

The concept of poverty was variously interpreted and imputed meaning by respondents. In all, lack of money 51(21.25%), lack of sources of livelihood 48(20.00%), lack of food 41(17.08%) and tattered dressing 25(10.42%) featured more prominently as interpretation of poverty by the respondents, in addition to prolonged ill health and lack of relations/kinsmen which accounted respectively for 14(5.83%) and 13(5.42%) of the total responses. In other words, poverty is a state of "lack" or "deficiency" in money, kinsmen and sources of employment that could yield money, food, good dressing and good health. According to Leftwich and Sharp (1978: 213), poverty is concerned with the relationship between the minimum needs of people and their ability to satisfy these needs. Health is one of such minimum needs which has to be satisfied. Lack of good health is therefore one of the indications of poverty.

The economic dimension of poverty is reflected in the high premium given to money and money-yielding sources in the town. The lack of money and money-yielding sources is bound to affect the nutritional status and the quality of dressing in a town like Calabar where lack of farmland is not an important indicator of poverty but rather good food, quality and neatness of dressing are culturally cherished. In the contrary, those in the rural areas, however, depend on agriculture and related activities (Bage: 2001), and in these rural areas lack of farmland is an important indicator of poverty (Charles: 1997). These cultural demands tend to infect even strangers and immigrants in Calabar town who are constantly reminded of the need to eat well and dress well, in addition to looking healthy and attractive. That is why prolonged ill-health is regarded as poverty because in ill-health one cannot eat well, dress well or look attractive. Apart from cross-cultural acceptance of the fact that "Health is wealth", it is idiomatically also expressed among Ibibio and Efik peoples that "a sick man does not compete favourably with his peers". It is therefore culturally accepted that sickness is poverty and as a sick man is a poor man. Poverty is a multi-dimensional phenomenon and this corroborates Jentchs (2000:5) finding that "poverty is not attributed to one main cause nor its reduction based on one main strategy".

Patients abandonment carries a lot of stigma and is not religiously or culturally approved. Apart from being an ungodly act (23.68%) and a display of wickedness (22.97%), 20.14% were of the opinion that it is a sign of "wretchedness" or distressing poverty. Some, 11.30% of the responses said such people were cursed and were seen as abnormal human beings. Notwithstanding the fact that patient abandonment is not religiously or culturally approved, some people still abandoned those they take to the hospital because of a number of reasons which cut across economic, infrastructural, behavioural, logistic and social factors.

Economic factors such as "lack of money" (25.52%) and "high cost of medical treatment" (25.22%) ranked 1st and 2nd among the various reasons advanced by the respondents for abandoning patients. Complexity and severity of the particular sickness for which the patient was taken to the hospital also accounted for patient abandonment. Severity of any illness calls for a prolonged stay and financial demands in the hospital. The high financial expectation of the sponsors soon become exasperation and frustration if the hope of quick recovery fails. Users' charges in the hospital is one of the economic factors which discourage people from using health facility (Jegede 1996:57); the present study has recorded that it also leads to patient abandonment.

"Long distance" and "no sleeping facilities" paired with a score of 9.50% each as the fourth factors leading to patient abandonment. Long distance is a logistic factor and sleeping facility is an infrastructural factor which impinge on each other. Many of the patients brought to the hospital are not urban dwellers and may not also have immediate relations in the town. The problem of movement to and from the hospital by relations in their effort to bring food to their sick ones is often compounded by the non-provision of sleeping

spaces for them in the hospital. This also explains why relations abandon their patients especially if the disease or sickness became very complex, prolonged and severe. Okafor (1982) has shown a negative relations' between distance or travel cost and the u' health care services; this research has f demonstrated that expenses incurred by ; relations arising from long distance also leads to patient abandonment after admission.

Behavioural perspective in patient abandonment is accounted for by the so-called "high handedness of nurses and doctors" (5.05%), "hospital workers' advice" (2.90%) and "ignorance" (0.60%). "High handedness" here refers to unfriendly and uncompromising attitude of doctors and nurses who always would insist on proper conduct by patients or patients' relatives in order to make the patient comfortable, relaxed, and quicken recovery while on admission. Such unfriendly and uncompromising attitude and behaviour of nurses, attendants and other teaching hospital staff reported by Kisseka (1992: xvii) include rudeness, aloofness and discrimination. In other situations also, respondents recalled that some hospital workers would advise patient relatives or sponsors to abscond, so that the Teaching Hospital Management would take full responsibility for the treatment and repatriation of the patient. Such advise usually is given if such "concerned" hospital workers are moved by sympathy because of the poor financial state of the patient and patient's relatives vis-à-vis the medical demands of the hospital.

An advise such as this may not be unconnected with the general belief that government should be responsible for the payment of medical bills of the citizenry. This belief was expressed by 77.00% of the respondents. Surprisingly, when respondents were asked specifically whether people abandon their patients because government should always carry out this role, 78.00% said "no" while only 22.00% said "yes". In other words, respondents did not see any relationship between peoples' perception of the role of government and the act of abandoning patients in the hospital. This tends to demonstrate the lack of relationship between what people perceive or believe as the role of government in health care delivery and the intent of their action. It becomes clear that people abandon patients not because government has refused to actualize their perception but more because of economic, infrastructural, behavioural, logistic and social factors.

The effects of patient abandonment are felt both by the general public and the hospital and have also tended to adversely affect the health care delivery system. For instance, the hospital has evolved more stringent health care policy aimed at enforcing deposit on admission. Hospital workers also tend to regard patients and their relatives with much suspicion and so try to rigidly enforce policies of the hospital management. This lack of confidence between patients and hospital workers endangers health and encourages a withdrawal syndrome between these two parties in health care delivery. Such an unfortunate development further alienates the patient in a modern health care delivery system (Jegede: 1996). Another deleterious effect of patient abandonment is the shortage of bed space available for other patients who should on admission enjoy such facilities. Such shortage in bed space could delay or frustrate immediate admission of paying patients into the appropriate wards where they would be properly treated. In such situations, social workers are often called in to hasten investigation and make recommendation.

In situations where abandoned patients do not pay hospital bills and are eventually declared paupers by the social worker, the burden of treatment, feeding and repatriation is left for the hospital to shoulder. In the process, the hospital might never be able to break even and may not create a conductive atmosphere for skill development of its staff and the treatment of diseases. This could eventually engender industrial conflict between hospital workers and hospital management and lead to failing morale, low motivation and decreased productivity/service and quality of service.

CONCLUSION

Patient abandonment remains a problem in the University of Calabar Teaching Hospital inspite of some progressive decline in recent years after the military era. It could thus be argued from the records that patient abandonment tends to be higher in despotic military rule than in democratic system of government. This may be explained away simply by the fact that people are more impoverished in military than in democratic system of government because of unprogressive economic policies and international economic sanctions usually imposed on such government.

The expectation of respondents that government should pay or subsidize hospital bills did not interpret in their action of

abandoning patients. This is so because neither the culture nor the religion of the people approved poverty or patient abandonment as virtues. Patient abandonment could therefore be seen as an action in desperation, driven mostly by the pangs of poverty, in complete deviance of culture, religion or deleterious consequences of such action on health care delivery system. This means, policy makers could alleviate the problem of poverty, ill health and patient abandonment by funding health care delivery system to benefit the poor and the sick in the society. Helping the sick through enabling health policies is one of such progressive actions in good governance (van de Sand: 2000).

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