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Perceptions of women on workloads in health facilities and its effect on maternal health care: A multi-site qualitative study in Nigeria

R.N. Ogu, FMCOG Consultant Obstetrician Gynaecologist and Senior Lecturer[a,d,e], L.F.C. Ntoimo, PhD Lecturer[b,d], F.E. Okonofua, FRCOG Professor of Obstetrics Gynaecology & Vice Chancellor[c,d,e,*]

[a] Department of Obstetrics and Gynaecology, University of Port Harcourt, Rivers State, Nigeria
[b] Department of Demography and Social Statistics, Federal University Oye-Ekiti, Ekiti State, Nigeria
[c] University of Medical Sciences, Ondo City, Ondo State, Nigeria
[d] Women's Health and Action Research Centre/WHO/FMOH/MNCH Implementation Research Group, Benin City, Nigeria
[e] Centre of Excellence in Reproductive Health Innovation, University of Benin, Benin City, Nigeria

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ABSTRACT

Objective: of the study was to explore women's perception of maternal health care providers' workload and its effects on the delivery of maternal healthcare in secondary and tertiary hospitals in Nigeria.
Research Design, setting, participants: five focus groups discussions (FGDs) were conducted with women in each of eight secondary and tertiary hospitals in 8 States in four geo-political zones of the country. In all, 40 FGDs were held with women attending antenatal and post-natal clinics in the hospitals. We elicited information on women's perceptions of workloads of maternal health providers and the effects of the workloads on maternity care. The discussions were audio-taped and transcribed while thematic analysis was carried out using Atlas.ti computer software.
Findings: the majority of the participants submitted that the health providers are burdened with heavy workloads in the provision of maternal health care. Examples of heavy workload cited included complaints from health providers, evidence of stress and strain in care provision by providers and the sheer numbers of patients that are left unattended to in health facilities. Poor quality care, insufficient time to carry out necessary investigations on patients, and prolonged waiting time experienced by women in accessing care featured as consequences of heavy workload, with the secondary result that women are reluctant to seek care in the health facilities because of the belief that they would spend a long time in receiving care.
Key conclusions and implications for practice: we conclude that women are concerned about heavy workloads experienced by healthcare providers and may partly account for the low utilization of referral health facilities for maternal health care in Nigeria. Efforts to address this problem should include purposeful human resource policy development, the development of incentives for health providers, and the proper re-organization of the health system.

Introduction

The high rate of maternal mortality in Nigeria is presently a major public health concern. With a population of 186 million persons and a maternal mortality rate of 814/100,000 births (UN Inter-agency Group for Child Mortality Estimation, 2013; World Health Organisation, 2015), Nigeria has one of the highest maternal mortality rates in the world. Over the past years, several publications have reported the inadequacy of Nigeria's health care system to address the provision and organization of services to address its high rate of maternal and child mortality (Asuzu, 2004; Shiffman and Okonofua, 2007; Welcome, 2011; Wollum et al., 2015). One of the major constraints is the quality and quantity of its labour force that is inadequate, poorly mobilized and weakly motivated to tackle the provision of high-quality obstetrics and emergency pregnancy care. Although Nigeria is reported to have the second highest quantum of human resources for health among all African countries, the effective and equitable utilization of the existing workforce has been less than optimal (World Health Organisation, 2017).

The migration of Nigeria's health labour force to western countries became manifest in the mid-1980s (Hagopian et al., 2004; Cometto

* Corresponding author at: University of Medical Sciences, Laje Road, Ondo City, Ondo State, Nigeria.
E-mail addresses: rosemary.ogu@uniport.edu.ng (R.N. Ogu), ntoimo.lorretta@fuoye.edu.ng (L.F.C. Ntoimo), feokonofua@yahoo.co.uk, vc@unimeds.edu.ng (F.E. Okonofua).

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et al., 2013) when the structural adjustment program came into being, but with increasing devaluation of the country's currency, the problem appear to have worsened. Estimates from the World Health Organization shows a density of about 200 physicians to 10,000 population in Sweden compared to only 4.1 physicians and 16.1 nurses and midwives in Nigeria (World Health Organization, 2015, 2017). Only about 3500–4000 doctors graduate yearly from medical schools in Nigeria (World Health Organization., 2016), yet a total of 2701 doctors left the country between 2009 and 2012. (International Organization for Migration (IOM), 2016). Among those that remain in the country, the majority work in large urban cities while only a few are to be found in the rural and hard-to-reach communities (Awofeso, 2010; Okoli et al., 2012).

Thus, a major characteristic of the public health facilities in Nigeria is under-staffing, with only a limited number of providers left to provide care for the teeming population of pregnant women. At the Aminu Kano Hospital, in Kano State, only five obstetricians are available to provide care for up to 15,000 pregnant women that visit the hospital on an annual basis (Galadanci et al., 2007). Similar situations apply in many hospitals, especially in northern Nigeria that experience high rates of maternal and newborn mortality. The shortage of staff and over-work of available staff is one of the very daunting situations faced by Nigeria's health care system, which has implications for both the quality of care and women's access to high-quality care. Studies conducted in Nigeria have shown that shortage of staff with consequent heavy workloads on existing maternal health care providers is associated with poor access to maternal health care and under-5 mortality (Adedini et al., 2014; Okeke et al., 2016), and ineffective and irregular maternal death audit in Northern Nigeria (Hofman and Mohammed, 2014).

Secondary and tertiary hospitals are referral hospitals in the country, which were designed to receive referrals from primary health care centres and private hospitals. Within Nigeria's health care system, the primary health centres are supposed to be the entry points into the health system, from where pregnant women with complications are referred to secondary and tertiary health centres. However, due to the low functionality of primary health centres throughout the country (Ehiri et al., 2005; Katung, 2000), women prefer to attend secondary and tertiary health facilities directly rather than go through the primary health centres. Although private health facilities abound in many of parts of the country, perceptions about their higher cost of services limit women's capacity to access them for private maternity services (Ogunbekun et al., 1999). This accounts for the increasing number of women who use the few existing public secondary and tertiary health facilities in the country for maternal health care. The objective of the study is to explore women's perceptions and experiences of this situation and how it affects maternity services in eight Nigerian secondary and tertiary hospitals. We believe the results would be useful to enable policymakers and other stakeholders develop policies and programs to improve the delivery of effective maternal health care for women attending secondary and tertiary health facilities in the country.

Study design, setting & population

A team consisting of obstetricians, statisticians, and demographers/sociologists conducted the formative assessment as part of an intervention research designed to find ways to improve the quality of maternal health care and reduce maternal mortality ratios in referral hospitals. It consisted of Focus Groups Discussions (FGDs carried out with various categories of women attending antenatal, delivery and postnatal care in six General hospitals (secondary care) and two Teaching hospitals (tertiary care) in eight States in four out of the six geo-political zones (GPZs) of the country (Table 1).

Administratively, Nigeria is made up of six GPZs (North Central, North East, North West, South East, South-South, and South West), and thirty-six states with a Federal Capital Territory, Abuja. Eight hospitals (from four GPZs) were selected to identify variations in the responses that women give in order to increase the theoretical transferability of the study findings to the wider Nigerian context. The two teaching hospitals selected for the study were in the North West zone(NGPZ). The secondary care facilities were in the South West(SGPZ); North Central(NGPZ); and South South geopolitical zone(SGPZ).Each hospital has the mission to deliver emergency obstetric services to pregnant women and attend to more than 2000 pregnant women each year. We paired hospitals in neighboring States, so as to provide opportunity for States, regional and national comparison of results of the study.

Table 1
Table showing the Hospital type and Geopolitical zones where the focus group discussions were undertaken.

Geo Political Zones		
	Secondary hospitals	Tertiary hospitals
North-West	0	2
North-Central	2	0
South-West	2	0
South-South	2	0
Total	6	2

Focus Group Discussions (FGDs) were conducted with women attending the antenatal and postnatal clinics in the 8 hospitals. Women were categorized into the FGDs by age (15 – 49years), social class (employment status; housewives and those engaged in the low wage informal sector e.g. petty trader, seamstress,), marital status (in union: married and living together) and places of residence (urban v. rural residences). The participants were recruited through personal contacts when they came for antenatal and postnatal clinics. Due to difficulty in recruiting women at the time of delivery, no FGD was conducted with women in labour. We waited until women delivered and returned for postnatal clinics before requesting them for permission to be included in the study.

Five FGDs were conducted in each of the health facility. Each FGD consisted of 8 -12 pregnant or recently pregnant women attending antenatal or postnatal clinics in the hospital respectively. Two FGDs consisted of women attending antenatal care, while three FGDs per hospital consisted of women attending postnatal care. The FGD guide was developed and revised by the team leaders at a central meeting held in the project coordinating office. The guide was pre-tested in that location and again pre-tested in the individual study sites before application. In particular, the study guides were translated into the local languages appropriate for the study sites and used for women groups not literate in English. The FGDs were designed to determine women's perceptions about the effects of workload on the quality of care they receive, and the effects of this on their use and access to the health facilities. Questions were asked by trained researchers who elicited information on women's perceptions of healthcare providers' workloads and its effects on the quality of maternal health care. Specifically, we asked them to elucidate the circumstances under which delays occur in the hospital, their perceptions about providers' workloads and the role of workloads of health providers as determinants of the quality of care they receive, and their access to health facilities. All questions were solicited in a value-free and unstructured manner, while women were requested to feel free to answer or not answer any question. All FGDs were audio-taped and transcribed in each hospital. Transcripts in local languages were back-translated to English before final analysis. The transcripts were then forwarded to the coordinating Centre where they were analysed qualitatively for form and content.