

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/319397077>

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

Article in *Midwifery* · August 2017

DOI: 10.1016/j.midw.2017.08.008

CITATIONS

0

READS

32

3 authors, including:



**Rosemary Nkemdilim Ogu**

University of Port Harcourt

40 PUBLICATIONS 90 CITATIONS

[SEE PROFILE](#)



**Lorretta Ntoimo**

Federal University Oye-Ekiti

12 PUBLICATIONS 14 CITATIONS

[SEE PROFILE](#)

Some of the authors of this publication are also working on these related projects:



Improving Maternal Health in Subsaharan Africa. [View project](#)



An Intervention to Increase Access to Youth Friendly Health Services in Andoni LGA of Rivers State, Nigeria. [View project](#)

## Outline

[Highlights](#)[Abstract](#)[Keywords](#)[Introduction](#)[Study design, setting&population](#)[Findings](#)[Discussion](#)[Conflict of Interest](#)[Ethical Approval](#)[Funding Sources](#)[Clinical Trial Registry and Registration number](#)[Acknowledgments](#)[References](#)[Show full outline](#) 

## Tables (2)

[Table 1](#)[Table 2](#)

Register to optimize your research with personalized recommendations 

Register now 







ELSEVIER

## Midwifery

Volume 55, December 2017, Pages 1-6



# 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) <sup>a, d, e</sup> , L.F.C. Ntoimo PhD (Lecturer) <sup>b, d</sup> , F.E. Okonofua FRCOG (Professor of Obstetrics Gynaecology&Vice Chancellor) <sup>c, d, e</sup>  

 [Show more](#)

## Highlights

- We investigate women's perceptions of maternal healthcare providers' workload.
- Large workload makes maternal healthcare providers give inadequate service.
- The inadequacy is a major disincentive for women's access to maternal healthcare.

## 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.

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.

## Keywords

Workload; Maternal Health; Hospitals; Perception; Women

---

## 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 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](#)).

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

<b>Geo Political Zones</b>		
	<b>Secondary hospitals</b>	<b>Tertiary hospitals</b>
<b>North-West</b>	0	2
<b>North-Central</b>	2	0
<b>South-West</b>	2	0
<b>South-South</b>	2	0
<b>Total</b>	6	2

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.

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.

## Data analysis

Qualitative data analysis package Atlas.ti 6.2 was used for coding. At the first step, transcripts were assigned into Atlas.ti and codes were generated following the FGD guide for the study, and emerging concepts. At the second level, the codes were organized into analytical categories in form of themes in relation to the study objectives.

Data analysis consisted of a description of the content and form of transcripts conducted at each site, followed by a review and comparison of the results between the sites. The results enabled us to gain insights into women's perceptions regarding access to maternal care, maternal deaths and what can be done to prevent them.

## Ethical approval

Ethical approval for the study was obtained. All women were informed of the purpose of the study, and they were assured of the confidentiality of information obtained. No names or specific contact information were obtained from study participants. Written informed consents for both the discussions and the audiotaping were obtained from the participants. They were informed that evidence generated from the study could inform policies made and change practices leading to the reduction of maternal mortality. They were also informed that they would incur no risk if they opt out of the study. Only those who agreed to participate in the fully explained study and gave written informed consent were recruited into the study.

## Findings

## Socio-demographic characteristics of the participants

A total of 339 women in all the hospitals participated in the 40 FGDs. The women were all pregnant or recently delivered women in the hospitals and ranged in age from 18–37 years (median = 24 years). A large proportion of the women (298/339 = 87.9%) had at least a primary school education. In the sections that follow, we present participants' varying perceptions about the scale of work by maternal health care providers and the perceived effects of the workload on women seeking maternal care in hospitals ([Table 2](#)).

Table 2. Perceptions of women on workloads in maternity hospitals and its effect on maternal health care: Quotations for specific codes and themes.

Codes	Number of Quotations	Theme
<b>MHCP overwhelmed by large scale of work - yes {49-0}</b>	49	Large scale of work
<b>MHCP overwhelmed by large scale of work - no {9-0}</b>	9	No large scale of work
<b>Effect of large scale of work - poor output {2-0} Effect of large scale of work - poor attention to patients {6-0}</b>	9	Sub-optimal care
<b>Effect of large scale of work - inadequate attention to patients {1-0}</b>		
<b>Effect of large scale of work - negative emotion like anger {1-0}</b>	2	Physical and Emotional Burn-out
<b>Effect of large scale of work - affect their physical ability to give care {1-0}</b>		
<b>Effect of large scale of work - not attending to some patients {3-0}</b>	4	Patients are left untreated
<b>Effect of large scale of work - congestion of patients {1-0}</b>		
<b>Effect of large scale of work - severe condition for women seeking emergency obstetrics care {2-0}</b>	14	Delay in initiating treatment
<b>Effect of large scale of work - long waiting time {6-0}</b>		
<b>Effect of large scale of work - delay to patients seeking emergency attention {1-0}</b>		
<b>Effect of large scale of work - delay in suturing after episiotomy {1-0}</b>		
<b>Code: Effect of large scale of work - delay in initiating</b>		



treatment {4-0}

Code: Effect of large scale of work - delay in getting effective care {2-0}

Code: Effect of large scale of work - scares pregnant women from seeking care in hospital {3-0} 3 Barrier to utilization of health facilities for maternal care

Code: Effect of large scale of work - risk of death {1-0} 1 Risk of maternal death

Code: Effect of large scale of work - deliberate late arrival to work by MHCP {1-0} 1 Depresses providers' motivation for work

Code: Effect of large scale of work - does not affect the quality of service {3-0} 3 No adverse effect

---

### Scale of work by maternal health care providers

The women were asked whether they think maternal health care (MHC) providers are burdened by large scale of work. Two categories emerged from their narratives 1) MHC providers are burdened with a large scale of work and 2) MHC providers are not burdened with a large scale of work.

#### MCH providers are burdened

The majority of the women submitted that maternal health care providers in the hospitals are burdened with a large scale of work. In one of the FGDs, the response to this question was a chorus by all the women “yes, they are over working; the workload is too much” (FGD 3, SGPZ). Stressing this perception, in another group, a woman narrated from her experience. She said:

Yes, the doctors are not many, ehnehn the work is too strenuous, like the last time I delivered here the doctor that was on duty, the doctor was on duty in the ehm delivery ward, he was still in the theatre, they you know [you understand?], so, the stress, even when I saw the doctor, I said, doctor, I know the doctor's name, I said doctor only you! He said yes oo. He looks as in messed up ... yes, the work is too much for them (FGD 1, SGPZ).

These respondents believed that the number of patients is increasing, and the health providers are few. One of the discussants opined: “Health providers try their best, despite the growing number of patients” (FGD 1, NGPZ). Attributing the large workload to inadequate providers, another participant observed with reference to the hospital she uses: “There are not enough doctors and nurses for the number of patients that come” (FGD 2, SGPZ).

Some of the participants commended maternal health care providers who do not behave as if the workload is too much for them. Commenting on this, a respondent said: “it is too much but even at that they don’t have any problem like fight and all that” (FGD 2, NGPZ). Another woman responded: “Yes, health providers are overwhelmed by the workload, but they do not make it obvious” (FGD 2, SGPZ). Another discussant in Kano stated: “sometimes we see it in their faces that the work is too much and they are tired” (FGD 4, NGPZ). However, a woman in Niger observed that sometimes nurses complain. In her words: “Yes, complaint by health care providers especially nurses” (FGD 4, NGPZ).

While admitting that health care providers are saddled with a large scale of work, some of the respondents observed that the large workload concentrates around the antenatal care clinic. A participant said: “Doctors and nurses are overwhelmed by the scale of work they do. For example, the providers at the antenatal clinic are too few” (FGD 5, SGPZ).

#### Providers are not burdened with large work load

On the contrary, some participants, particularly in NGPZ stated that the workload is not too much for the providers. In FGD 4 in Abuja, all the respondents submitted that the workload is not too much. Corroborating, a participant in Kaduna said: “I don't think they are excessively loaded with work” (FGD 2, NGPZ). Five others in this group concurred with her and attributed the large workload to late arrival to work by the health care providers. One of them said: “The problem emanates from late arrival to work but not the workload placed on them” (FGD 2, NGPZ). Some of the women in this category observed that the providers’ attitude to work contributes to what seems to be large workload. In FGD 5 in Kaduna, it was the opinion of 8 out of ten discussants that the health care providers are not overwhelmed by large scale of work. A respondent observed: “Nurses at the antenatal clinic are lazy and they intentionally delay patients” (FGD 5, SGPZ).

#### Effects of large scale of work on maternal healthcare

The views of the women were sought on the effect of large scale of work by providers on women seeking maternal healthcare services in the hospitals. Several effects were evident from the narrative of the women.

#### Sub-optimal care

Many respondents believed that large scale of work makes maternal health care providers give inadequate and poor attention to patients. Speaking on this, a discussant said: “sometimes they won’t attend to you the way they are supposed to, you can be there and someone will enter, then they will leave you, the work is too much and even the nurses are not many” (FGD 4, NGPZ). Stressing on this effect, a discussant in another group observed: “if the doctor says he is going to see fifty people, the way he will attend to the first fifteen will not be the same way he will attend to others” (FGD 5, NGPZ). In specific reference to the antenatal clinic, a participant reported: “In the antenatal clinic,

the overwhelming volume of patients does not permit the nurses to carry out a thorough examination of a patient” (FGD 4, SGPZ). In Kaduna, five participants expressed their displeasure with poor attention to women, particularly during labour and childbirth. One of them said: “Poor attention given to patients is painful especially during labour or childbirth” (FGD 3, NGPZ).

### Physical and emotional burn-out

A few of the women associated poor and lack of attention to patients by the providers to physical exhaustion arising from the large scale of work. A respondent observed: “the doctor will see ten to twenty people but since he is tired he won’t attend to others well, they should employ more workers” (FGD 5, NGPZ). Another woman affirmed: “yes because really, they are tired and they can say I can’t attend to you and we take it as an offense” (FGD 4, NGPZ). Tiredness may also result in irritable behaviour to patients. A discussant stated: “yes, sometimes only two doctors will attend to all the patients, so they will get tired easily and may even get angry easily” (FGD 4, SGPZ).

### Patients are left untreated

Not only that providers’ large scale of work results in the provision of sub-optimal care, according to the women, some of the discussants observed that some patients are left untreated sometimes. Speaking from her own experience, a discussant said: “during ante-natal, because people are too many, they attend to some and don’t attend to others. I came like six times and didn’t see a doctor” (FGD 3, NGPZ). Another discussant stated: “sometimes when you come for ante-natal, even at 6am, the booking will be filled up, or if they call names and it gets to your turn, they will say they have closed and unless it is an emergency or the case is too serious, then they will (not) attend to you” (FGD 4, NGPZ). It was observed that large scale of work by the providers affects prompt attention even in emergency cases. One of the participants said: “It causes unprecedented delays to patients seeking emergency attention” (FGD 5, NGPZ). A few of the women associated poor and lack of attention to patients by the providers to physical exhaustion arising from the large scale of work. A respondent observed: “the doctor will see ten to twenty people but since he is tired he won’t attend to others well, they should employ more workers” (FGD 5, NGPZ). Another woman affirmed: “yes because really, they are tired and they can say I can’t attend to you and we take it as an offense” (FGD 4, NGPZ). Tiredness may also result in irritable behaviour to patients. A discussant stated: “yes, sometimes only two doctors will attend to all the patients, so they will get tired easily and may even get angry easily” (FGD 4, SGPZ).

### Delay in initiating treatment

Delay in the initiation of treatment arising from long waiting time was commonly reported as an effect of large scale of work in many groups. A respondent observed: “It causes unnecessary delay in initiating treatment” (FGD 4, NGPZ). Another woman asserted:

“The result is negative, as a large number of patients will be forced to keep waiting for the arrival of the doctor longer than necessary” (FGD 1, NGPZ). In another FGD, a woman said: “sometimes the doctor can be checking those that are too unconscious and if yours is not too serious, they can leave you and come back to you later, if there are doctors they can attend to everyone” (FGD 4, NGPZ). In Ogun, a respondent reported: “yes, it causes delay, we have to wait a longer time before we are attended to” (FGD 5). Another respondent observed: “it causes a problem because if a woman gives birth in the night they won’t sew her [episiotomy] until the next morning; it is painful” (FGD 5, NGPZ). Also, observed by the women is that large scale of work by the providers affects prompt attention in emergency cases. One of the participants said: “It causes delays to patients seeking emergency attention” (FGD 5, NGPZ). Specifically, inadequate doctors were stated as a major reason for the long waiting time arising from the large scale of work. Expressing this view, a participant said:

Yes, I would say that they are lacking doctors here, not nurses, the doctors they are not enough. The same doctor you see here is the same doctor that will be waiting in the hmm maternity, hmmm labour ward, you know theatre or antenatal, the same doctor you see here. There are sometimes in that antenatal we will “stay ooh” waiting for a doctor from at least 8:00 am. If treatment should commence in time, at least before 10 am you will get to your house in time, but 10 am you will not see a doctor; it will be 11am, 12 noon before the doctor will be coming. Of course, in my own opinion, I know they are attending to some people somewhere, but some of them should be here also. As you [the doctors] are attending here that's how they need you [the doctors] in antenatal. You know, so, that is what they are lacking, they are lacking doctors (FGD 2, SGPZ)

#### Barrier to utilization of health facilities for maternal care

Closely associated with long waiting time, respondents also submitted that large scale of work by the providers scare some women from seeking care in hospitals. One of them said: “Some women refuse attending hospitals for health care services to avoid delay caused by lack of staff to attend to them” (FGD 1, NGPZ). Another one observed: “It could discourage others with the same problem to go for treatment” (FGD 4, NGPZ).

#### Risk of maternal death

In the opinion of the women, the large scale of work by providers increases the risk of maternal death. A respondent who emphasized this effect said: “Women with serious maternal health disorder are at risk” (FGD 1, NGPZ).

#### Depresses provider's motivation for work

Some of the women were of the view that large scale of work makes some of the health care providers to deliberately report late to work. One of the discussants submitted: “some staff deliberately refuse to report to the office in good time and when they arrive, they indulge in conversation with their colleagues” (FGD 4, NGPZ).

#### No adverse effect

Some of the participants were of the perception that the large workload does not affect the quality of service maternal health care providers give. However, this view was expressed only in Oyo in three different FGDs. Speaking on this, one of the respondents said: “Yes, health providers are overwhelmed by the workload, but that does not affect the quality of the services rendered” (FGD 2, SGPZ).

## Discussion

The objective of this study was to explore women's perceptions of how institutional workload affects the maternity care in referral hospitals. The results indicate that women in all the hospitals studied are aware and fully concerned about the large scale of work by maternal health care providers and its effects on maternity care.

Study participants in this study cited many examples of heavy workload. These include complaints by health providers, evidence of stress and strain in the provision of care by providers and the sheer number of patients that are left unattended to in health facilities on a daily basis. Women also provided reasons and explanations for the increasing workload, which include fewer numbers of health providers (especially doctors), and increasing number of patients that attend referral facilities. Indeed, several reports indicate that referral hospitals in Nigeria are understaffed and under-funded ([Awofeso, 2010](#); [Uzochukwu et al., 2015](#)). Existing staff are poorly motivated, hence their inability to deliver optimal care to the increasing number of patients ([Awofeso, 2010](#)). This is consistent with findings in several studies from low income countries ([Fonn et al., 2001](#); [Wamalwa, 2015](#); [World Health Organisation, 2006](#)), which suggest heavy workload is a disincentive to the provision of good quality maternal health care. In Ghana, increased workload is also reported as a major challenge in the provision of quality maternal health care at the facility level ([Banchani and Tenkorang, 2014](#)). It is noteworthy that the focus group participants in hospitals in the northern geopolitical zones were more likely to report high workload as a major problem as compared to those in the southern geopolitical zone. This, no doubt, is due to the greater scarcity of health human resource in the northern zone as compared to the southern parts of the country. This, no doubt, is due to the greater scarcity of health human resource in the northern zone as compared to the southern parts of the country ([Galadanci et al., 2007](#); [Nyango et al., 2010](#)). Clearly, a policy of sustainable human resource development needs to be developed that would enable the adequate recruitment and maintenance of health workforce to deal with the

high rate of maternal health care in the country. Available health providers also need to be better distributed to ensure that all health facilities including those in hard to reach communities are covered. A proper re-organization of services to increase the functionality of primary health centres and lower cost of services by private providers will increase the number of outlets for the delivery of primary maternal health services. This will likely reduce the workload on secondary and tertiary health facilities.

The results of this study also showed that heavy workload has multiple effects on the provision of quality care and reduces women's access to quality evidence-based maternity care. Some consequences proffered included a delay in the initiation of treatment, provision of low-quality care, insufficient time to carry out necessary investigations on patients, and prolonged time of patients in accessing care. A secondary result is a tendency for women not to seek care in the health facilities because of the belief that they would spend a long time in receiving care. In a study where we followed up women receiving care in various departments in 8 hospitals in Nigeria using process mapping, we determined that women spent an average of 301 minutes (5 hour) in receiving care. Another study conducted in Nigeria identified a shortage of staff and the consequent heavy workload as a barrier to women's access to skilled maternal health care with significant impact on child survival in the country ([Adedini et al., 2014](#)).

Ensuring that skilled attendants attend to women during pregnancy, delivery and postnatal care is currently one of essential interventions recommended by the WHO for reducing maternal morbidity and mortality in developing countries. If pregnant women are discouraged from accessing maternity care because of delays in care provision, it will result in a significant reduction of the proportion of women attended by skilled providers. The disincentive engendered by the delay in health facilities due to the high burden of work of health providers is clearly a major factor that leads women to unskilled providers such as traditional birth attendants and faith-based providers. An approach based on high-level advocacy for policy re-orientation to enable proper allocation of resources and the development of appropriate policies to deal with the problem is urgently required.

The major strength of the study is its multi-centre design and our focus on eliciting information from women using referral services in four of the six geo-political zones of the country. This approach allows for national transferability of the results of the study and its use for policy design and implementation throughout the country.

However, a limitation of this study is our focus on women who use the referral hospitals rather than all women. It is possible that the perspectives of women not using the hospital may be different, as indeed, women not using the hospitals may have stronger views about the effects of heavy workloads than those using the hospitals. The desire not to experience the effects of heavy workload may be a reason that some women did not use the hospitals. Thus, it would have been important to seek the perceptions of women not

using the hospitals. Also, the conduct of the focus group discussions within the hospital setting may possibly ameliorate or accentuate the views of the women on matters relating to the effect of workload. However, this also has its benefits as it ensures that women are able to relate to their immediate experiences in the use of the facilities.

Nevertheless, the results of the study have important implications for the design of interventions to improve maternal health in Nigeria, especially the development of policies to address the human resource needs and the equitable distribution of health workers for maternal health throughout the country. To achieve the desired results and outcomes, the voices of women as critical end-users should be taken into account in the design of policies and programs aimed at improving the quality of maternal health care in the country.

In conclusion, the results of this study indicate that women are concerned about heavy workload and the inadequacy of human resources to deal with maternal health care in referral hospitals in Nigeria. This inadequacy is a major disincentive to women's access to high-quality evidence-based care and is possibly a leading associated cause of the high rate of maternal mortality in the country. Efforts to address this problem should include purposeful human resource policy development, the development of incentives for health providers over-burdened by a high load of work, and the proper re-organization of the health sector so that women not requiring sophisticated care are attended to at primary health care centres rather than at higher levels of care.

## Conflict of Interest

None declared.

## Ethical Approval

Ethical approval for the study was obtained from the World Health Organization and the National Health Research Ethics Committee (NHREC) of Nigeria – number NHREC/01/01/2007 – 16/07/2014, renewed in 2015 with NHREC 01/01/20047-12/12/2015b. All women were informed of the purpose of the study, and they were assured of the confidentiality of information obtained. Only those who agreed to participate in the fully explained study were recruited into the study.

## Funding Sources

The project was funded by the Alliance for Health Policy and Systems Research, World Health Organization (Implementation Research Protocol ID [A65869](#)).

## Clinical Trial Registry and Registration number

Nigeria Clinical Trials Registry. <http://www.nctr.nhrec.net/>.

## Acknowledgments

This study was conducted in 8 sites (hospitals) in Nigeria by the WHARC/WHO Maternal Newborn Child Health Implementation Research (MNCHIR) group in Nigeria, with the under-listed members actively coordinating the data collection and research in the various sites: 1) Professor H Galadanci, Aminu Kano Hospital, Kano; 2) Dr. Abdullahi Randawa, Ahmadu Bello Teaching Hospital, Zaria; 3) Dr. Rukayat A Abdus-salam, Adeoyo Hospital, Ibadan; 4) Dr. Mohammed Gana, General Hospital, Minna; 5) Dr. Ola Okike, Karshi General Hospital, Abuja; 6) Dr. Kingsley Agholor, Central Hospital, Warri; 7) Dr. Eghe Abe, Central Hospital, Benin City; and 8) Dr Adetoye Durodola, State Hospital Abeokuta.

Professor Eze Nwokocha – Medical Sociologist and Anthropologist, University of Ibadan conducted the qualitative data analysis.

We are grateful to Dr. Taiwo Oyelade and Dr. Mariana Widmer of the Nigeria and Geneva offices of the WHO for their support.

Recommended articles

Citing articles (0)

## References

[Adedini et al., 2014](#) S.A. Adedini, C. Odimegwu, O. Bamiwuye, O. Fadeyibi, N. De Wet

**Barriers to accessing health care in Nigeria: implications for child survival**

Global Health Action, 7 (2014)

[Asuzu, 2004](#) M. Asuzu

**The necessity for a health systems reform in Nigeria**

Journal of Community Medicine Primary Health Care, 16 (2004), pp. 1-3

[Awofeso, 2010](#) N. Awofeso

**Improving health workforce recruitment and retention in rural and remote regions of Nigeria**

Rural Remote Health, 10 (2010), p. 1319

[Banchani and Tenkorang, 2014](#) E. Banchani, E.Y. Tenkorang

**Implementation challenges of maternal health care in Ghana: the case of health care providers in the Tamale Metropolis**

BMC Health Services Research, 14 (2014), p. 7, [10.1186/1472-6963-14-7](#)

[Cometto et al., 2013](#) G. Cometto, K. Tulenko, A.S. Muula, R. Krech

**Health Workforce Brain Drain: From Denouncing the Challenge to Solving the Problem**

PLoS Med, 10 (9) (2013), p. e1001514, [10.1371/journal.pmed.1001514](#)



- Ehiri et al., 2005* J.E. Ehiri, A. Oyo-Ita, E. Anyanwu, M. Meremikwu, M. Ikpeme  
**Quality of child health services in primary health care facilities in south-east Nigeria**  
Child: Care, Health and Development, 31 (2005), pp. 181-191
- Fonn et al., 2001* S. Fonn, A.S. Mtonga, H.C. Nkoloma, G. Bantebya Kyomuhendo, L. Silva, E. Kazilimani  
**Health providers' opinions on provider-client relations: results of a multi-country study to test Health Workers for Change**  
Health Policy Plan (2001), p. 16, [10.1093/heapol/16.suppl\\_1.19](https://doi.org/10.1093/heapol/16.suppl_1.19)
- Galadanci et al., 2007* H. Galadanci, C. Ejembi, Z. Iliyasu, B. Alagh, U. Umar  
**Maternal health in Northern Nigeria—a far cry from ideal**  
BJOG: An International Journal of Obstetrics Gynaecology, 114 (2007), pp. 448-452
- Hagopian et al., 2004* A. Hagopian, M.J. Thompson, M. Fordyce, K.E. Johnson, L.G. Hart  
**The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain**  
Human Resources for Health, 2 (2004), p. 17
- Hofman and Mohammed, 2014* J.J. Hofman, H. Mohammed  
**Experiences with facility-based maternal death reviews in northern Nigeria**  
International Journal of Gynecology Obstetrics, 126 (2014), pp. 111-114  
Article  PDF (186KB)
- International Organization for Migration (IOM), 2016* International Organization for Migration (IOM), 2016.  
Migration in Nigeria: A Country Profile 2014 - | IOM Online Bookstore. Retrieved 30 July 2017, from  
<<https://publications.iom.int/books/migration-nigeria-country-profile-2014>> .
- Katung, 2000* P. Katung  
**Socio-economic factors responsible for poor utilisation of the primary health care services in a rural community in Nigeria**  
Nigerian Journal of Medicine: Journal of the National Association of Resident Doctors of Nigeria, 10 (2000), pp. 28-29
- Nyango et al., 2010* D.D. Nyango, J.T. Mutahir, E.P. Laabes, J.H. Kigbu, M. Buba  
**Skilled attendance: the key challenges to progress in achieving MDG-5 in north central Nigeria: original research**  
African Journal of Reproductive Health, 14 (2010), pp. 129-138
- Ogunbekun et al., 1999* I. Ogunbekun, A. Ogunbekun, N. Orobato  
**Private health care in Nigeria: walking the tightrope**  
Health Policy and Planning, 14 (1999), pp. 174-181
- Okeke et al., 2016* E. Okeke, P. Glick, A. Chari, I.S. Abubakar, E. Pitchforth, J. Exley, O. Onwujekwe  
**The effect of increasing the supply of skilled health providers on pregnancy and birth outcomes: evidence from the midwives service scheme in Nigeria**  
BMC Health Services Research, 16 (2016), p. 425

*Okoli et al., 2012* U. Okoli, M.J. Abdullahi, M.A. Pate, I.S. Abubakar, N. Aniebue, C. West

**Prenatal care and basic emergency obstetric care services provided at primary healthcare facilities in rural Nigeria**

International Journal of Gynecology Obstetrics, 117 (2012), pp. 61-65

Article  PDF (219KB)

*Shiffman and Okonofua, 2007* J. Shiffman, F. Okonofua

**The state of political priority for safe motherhood in Nigeria**

BJOG: An International Journal of Obstetrics Gynaecology, 114 (2007), pp. 127-133

*UN Inter-agency Group for Child Mortality Estimation, 2013* UN Inter-agency Group for Child Mortality Estimation

**Levels and Trends in Child Mortality**

United nations Children's Fund, New York (2013)

*Uzochukwu et al., 2015* B. Uzochukwu, M. Ughasoro, E. Etiaba, C. Okwuosa, E. Envuladu, O. Onwujekwe

**Health care financing in Nigeria: implications for achieving universal health coverage**

Nigerian Journal of Clinical Practice, 18 (2015), pp. 437-444

*Wamalwa, 2015* E.W. Wamalwa

**Implementation challenges of free maternity services policy in Kenya: the health workers' perspective**

Pan African Medical Journal, 22 (2015), [10.11604/pamj.2015.22.375.6708](https://doi.org/10.11604/pamj.2015.22.375.6708)

*Welcome, 2011* M.O. Welcome

**The Nigerian health care system: need for integrating adequate medical intelligence and surveillance systems**

Journal of Pharmacy and Bioallied Sciences, 3 (2011), p. 470

*Wollum et al., 2015* A. Wollum, R. Burstein, N. Fullman, L. Dwyer-Lindgren, E. Gakidou

**Benchmarking health system performance across states in Nigeria: a systematic analysis of levels and trends in key maternal and child health interventions and outcomes, 2000–2013**

BMC Medicine, 13 (2015), p. 208, [10.1186/s12916-015-0438-9](https://doi.org/10.1186/s12916-015-0438-9)

*World Health Organisation, 2006* World Health Organisation, 2006. Improving Health Worker Performance: In Search of Promising Practices. Retrieved 30 July 2017, from

[http://www.who.int/hrh/resources/improving\\_hw\\_performance.pdf](http://www.who.int/hrh/resources/improving_hw_performance.pdf) .

*World Health Organisation, 2015* World Health Organisation

**Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division**

World Health Organisation, Geneva, Switzerland (2015)

*World Health Organisation, 2017* World Health Organisation, 2017. WHO | Human Resources for Health, Country Profile Nigeria. Retrieved 5 August 2017, from

[http://www.who.int/workforcealliance/knowledge/resources/hrh\\_profile\\_nigeria/en/](http://www.who.int/workforcealliance/knowledge/resources/hrh_profile_nigeria/en/) .

[World Health Organization, 2015](#) World Health Organization

### World health statistics 2015

World Health Organization (2015)

[World Health Organization, 2016](#) World Health Organization, 2016. WHO | World Health Statistics 2016:

Monitoring health for the SDGs. Retrieved 30 July 2017, from

[http://www.who.int/gho/publications/world\\_health\\_statistics/2016/en/](http://www.who.int/gho/publications/world_health_statistics/2016/en/) .

[World Health Organization, 2017](#) World Health Organization, 2017. WHO | Density of Nursing and Midwifery

Personnel (total number per 1000 population, latest available year). Retrieved 30 July 2017, from

[http://www.who.int/gho/health\\_workforce/nursing\\_midwifery\\_density/en/](http://www.who.int/gho/health_workforce/nursing_midwifery_density/en/) .

© 2017 Elsevier Ltd. All rights reserved.

## Recommended articles

No articles found.

## Citing articles (0)

# ELSEVIER

[About ScienceDirect](#) [Remote access](#) [Shopping cart](#) [Contact and support](#) [Terms and conditions](#)

[Privacy policy](#)

Cookies are used by this site. For more information, visit the [cookies page](#).

Copyright © 2017 Elsevier B.V. or its licensors or contributors. ScienceDirect ® is a registered trademark of Elsevier B.V.

 RELX Group™