Implication of Cultural Practices on Hospital Ward Setting in Nigeria

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Abstract: Hospital ward was configured to provide almost constant monitoring and observation of patients. In this situation all extraneous attributes such as the home like environment, families, and casual activities were excluded. However evidence based healthcare design prompted the increasing need in creating a homelike healthcare environment that provides for social support and tolerates patient’s cultural values. Unfortunately, the Nigerian hospital’s setting, were not configured to provide for such practices thereby resulting to more stress, dissatisfaction of the environment and the service provision. This qualitative study investigated the design implication of cultural attributes and practices of patients and their families in male and female surgical wards of one of Nigeria’s tertiary hospital, to identifying design indices that will inform design decision. Observation of activities and interactions of patients, families and the healthcare personnel was conducted. Field notes and photographs were analyzed and coded using content analysis. The interview conducted with five respondents, female (n=3) and male (n=2) was transcribed verbatim. The result indicate that patients’ satisfaction with care is a factor of their cultural attributes suggesting that, hospital design in Nigeria has to be configured to provide for such cultural practices in order meet the user satisfaction and improve restoration.

Keywords: Cultural attributes, Healthcare provision, User satisfaction, Evidence based design, Hospital ward

1. Introduction

Hospital was configured as an ‘examining apparatus’ that provides for almost constant monitoring and observation of patients. In this situations all extraneous attributes such as the home like environment, families, friends and casual activities were excluded, thereby making hospital to be an ideal laboratory setting where the causes of symptoms could be isolated and the effects of treatment monitored. However evidence based healthcare design prompted the increasing need in creating a homelike healthcare environment that provides for social support and tolerate patient’s cultural values. Some studies revealed that users direct involvement throughout the design process of a building is regarded as the most valid and democratic means accommodating user needs(Ananth, 2008). Plethora studies revealed the significance of understanding, tolerating and respecting patients’ cultural attributes for attainment of required clinical outcome. Such cultural values have been identified to shape how patients understand, manage and cope with sickness, make meaning of diagnosis and consequences of treatment.

2. Cultural attributes and Health Beliefs

Designers and other professionals involved in healthcare facility provision requires a more informed
understanding and consideration of the rich and diverse array of beliefs, expectations, preferences, and behavioral makeup of the social cultures of a particular setting so as to provide the best and most comprehensive design possible (Maya, White, & Fetters, 2005). This will further enhance provider’s ability to offer better healthcare provision and to build patients trust and confidence.

Further studies in this regard has shown how the understanding the ideal perspectives and beliefs of individual patient became a vital component in culturally competent healthcare provision (Maya et al., 2005), to this extent, healthcare providers need to familiarize themselves with the normative cultural values affecting interactions with their patients from different cultures (Carteret, n.d.). Moreover, understanding and tolerating the socio-cultural dimension of a patient’s health beliefs has been identified to be very essential for a successful clinical outcome (Ariff & Beng, 2006).

Different cultures have different systems of health beliefs that tells what causes illness, how it should be cured or treated, and who should be involved in the process and where the treatment takes place. Studies has indicated that, the extent to which programs and interventions alienate to their belief, the more it make profound effect on their reception to medication provided and their willingness to use it (Day & Cohen, 2000). While some see disease as a result of natural scientific phenomena especially in advanced countries who advocate medical treatments in fighting microorganisms or use of sophisticated technology in diagnoses and treatment (Wagner, 2000), some societies believe that illness is the result of supernatural phenomena hence they employ prayer or other spiritual interventions counteracting the presumed disfavor of powerful forces (Ivtzan, Chan, Gardner, & Prashar, 2013). This suggest that cultural beliefs play a vital role in patients’ satisfaction with the environment they receive medication and treatment thereby making healthcare provision taking different dimensions that has to fit in to a particular setting.

Plethora of studies in this context shows that people from different cultural background comply with medical protocols that only conform with their cultural norms and practices (Day & Cohen, 2000). It is therefore generally believed that for effective healthcare delivery, the cultural characteristics of a particular group need to be identified in order to tailor programs and interventions that will perfectly meet the needs of its members (Murry, 2011). However, inability to understand and respond appropriately to the normative cultural values of patients and their families results into variety of negative clinical challenges that involves reduced participation in prevention of screenings, refusing immunizations, use of harmful remedies, erroneous histories, non-compliance, and dissatisfaction with care among others (Koenig, George, & Siegler, 1988).

A major challenge involved in providing a setting for patients from different cultural backgrounds is the ability to apply cultural generalizations appropriately while maintaining prospects of the individual patient/family. To succeed in this, designers has to bear in mind the variations among cultural subgroups. Moreover, factors, such as socio-economics, language, religion and diet have an enormous impact on a person’s health beliefs and behaviours.

For example, Studies among some sub-populations of cultures from India and Pakistan indicates that people feel reluctant in accepting a diagnosis that has to do with severe emotional illness and mental retardation (Day & Cohen, 2000) whereas studies among Hmong people in America who due to their unique cultural beliefs and indigenous practices, often present a unique set of challenges to healthcare professionals. This is due to their low adaptation of the modern model of healthcare delivery that has been strongly attributed to their traditional beliefs, culturally-based patterns of communication and limited English proficiency.
Furthermore, studies by Maya, Casey and Fetters (2005) has indicated that, for a successful programme and intervention to American Arabs or American Muslims, their cultural and religious requirements and preferences (dress, privacy, gender, dietary regiments and medications) that impact clinical care must be considered (Maya et al., 2005). In addition sensitive clinical care that has to do with sexuality, circumcision, adoption and hospices care need to be handled with caution (Maya et al., 2005).

3. Inpatient Design and Evidence Based Practices

The patient room commonly known as ward is mostly considered as a focal point of the bio medical treatment in a hospital setting, to this end, it was configured as an ‘examining apparatus’ that provides for almost constant monitoring and observation of patients being an environment where patients spend most of their hospitalisation period.

Therefore, the environment needs to be made conducive to all the occupants especially the patient. To this end several studies were conducted to determine the effect of various environmental factors on the healthcare facilities and health outcome.

Much earlier studies in this regard looked at number of environmental issues, that has to do with indoor environment; ventilation, temperature, privacy and noise (Harris, McBride, Ross, & Curtis, 2002), others focused on windows, light, plants, music, cleanliness, drainage, wall finishes, furnishings, and even color (AIA, 1996). Later studies revealed that, the previous healthcare facility design reflected more of an institutional than a humanistic, not until fairly recently when the proliferation of studies in healthcare design of the 19th and early 20th centuries prompted evidence based design in which, healthcare facilities designs were not only guided by changing views of disease and treatment, but by the functional needs of medical staff, and by continuous changing requirements that accommodate new medical technologies (Ulrich, Xiaobo, Craig, Anjali, & Ruchi, 2004).

While these factors continue to play a vital role in healthcare facility planning and design, there has been rising need to focus more on user satisfaction. The consideration for patients’ and families needs in the design process raises a growing concern to the designers and researchers within health care over the issues of patient satisfaction through service quality. Service quality alongside clinical quality are now considered as primary guiding principle in health care delivery, with patient satisfaction measures as a yard stick in assessing and monitoring service quality (Sitzia & Wood, 1997).

These measures reflects various perspective, with patient satisfaction commonly regarded as identifying and respecting patients’ culture, beliefs, attitudes, expectations and needs (Sitzia & Wood, 1997). This suggests that the design of patient rooms should be studied from the patient, staff, and family perspectives with a view to have their particular needs and desires identified and met.

To this end there a lot has been documented on the need for patients to have easy access, safety/security, privacy, accommodations for family, positive diversion/distraction. However little has been documented on the need to understand the differences and communalities of various cultural attributes that designers put into consideration during facility design (Chang & Harden, 2002).

Culture has become a very sensitive and a vital issue in a growing multi ethnic society where hospital facility design stereotyping is proving insufficient and inadequate in satisfying the end users especially in Nigeria where people always identify themselves with their cultural attributes in whatever setting they may find themselves especially hospital wards.

Nigerian public hospital wards mostly characterised by the famous open multi bed ward is experiencing serious challenges in synchronizing formal and informal activities of the patients within the hospital spaces (Alkali, Ahmad, & Said, 2014). The patients mostly accompanied by their families find it difficult in finding their daily activities fit into
the hospital spaces thereby suggesting a customized hospital ward configuration that have considerations for their cultural attributes (Alkali et al., 2014).

4. Study Design and Setting

Qualitative research approach as employed by social scientist to examine culture and human behaviour within of a group of people within a setting (Elo et al., 2014; Taylor-Powel & Steele, 1996), was adopted in both male and female wards in one of the Nigeria’s tertiary hospitals, Federal Medical center Gombe. This is a hospital with 450 bed capacity situated at the north eastern geopolitical region of the country. Ethical clearance was granted by the research and ethics committee of the hospital. Moreover, informed consent was sought from the patients who participated in the interview. The observation was conducted in an open hospital wards setting of 36 beds each clustered into bays of six and four beds with centralised nurses station and attached conveniences. The male and female wards are positioned adjacent and mirror to one other approached by main entrance corridor.

An unstructured interview with the patients was employed for a free flow of conversation without cues (Elo et al., 2014; Pattison & Robert, 1996), so as to have a better understanding of the observed themes. Seven participants were selected based on their willingness and ability and were earlier informed that the participation is voluntary. The inclusion criteria was patients that spent at least four days on admission who are conversant with the environment and understands the purpose of the survey.

5. Data Collection

The observation was carried out in three sessions of eight hours each spread across three consecutive days for convenience. The morning, afternoon and Night sessions were scheduled from 5am to 1pm, 1pm to 9pm and 9pm to 5am respectively for the first day. This morning session was intended to observe the early morning, pre ward round and during ward round activities, afternoon session was to capture the post ward round activities, meals and other related activities whereas he night session was to observe the overnight activities. The sessions were conducted in each of the male and female wards. The average occupancy as at the time of the observation was 26 beds out of the 32 in the male ward, and 28 beds out of the 32 in the female wards.

Formal introduction of the investigator was made by the nurse in charge of the wards to his colleagues afterwards. The healthcare personnel attached to the wards are three nurses, two health assistants and a porter in each of the wards. Furthermore, patients and their relatives were also informed of the purpose of the study. Activities and interactions of the patients, their families and healthcare personnel, immediate field notes were taken and picture photographs also taken with the consent of the subjects. The observation covers the behaviour, attitudes and activities of the patients and their family during the hospitalisation period and how that relates to the hospital ward setting. Meanwhile, the assessment started with the study of the activities around the bed space and extended to the remaining ward environment.

The researcher interviewed the patients to understand their experience of the environment with the family participation. Seven patients were interviewed male (n=5) and female (n=2). The interview took place in local language Hausa by the bed side before or after the beginning of observation sessions.

6. Methodological Validity

To insure rigour in the methodology, a prolonged engagement in the field and the use of both the observation and interview was used. In addition, the photograph snapshots and audiotapes were used alongside the field notes. The observation for each session was repeated in both the female and male wards to ensure consistency and each bed side was observed at least twice. The interview was conducted before the analysis of data from observation in order
to minimise the influence of observational data on the study (Coughlin, 2013). At the end of each interview, the content is summarised to be sure that the meaning of the recorded content.

7. Data Analysis

Information from field notes and the photographs were analysed using constant comparison analysis (Leech, 2007). Data obtained in the female ward was compared to that of male ward for conformability (Elo et al., 2014). Furthermore, Activity was identified to be the major social unit in the analysis (Elo et al., 2014). This is the tag employed by people to organise their own actions and one that is used on others as a way of making sense out of it (Street & Coleman, 2012). Moreover, it was as well used as the major unit of analysis in order to match the main purpose of the study, which was identifying cultural attributes themes from the activities of patients and their families during the period of hospitalisation. Five other social units (practices, episodes, encounters, meanings, and relationships) as used by were also considered for relevancy so as to help in describing resultant effects of patients and their families’ culture within the hospital ward setting (Elo et al., 2014). To achieve data reduction, and comprehension, codes were generated accordingly in recognition of when and where such activities take place (Patton, 1990). Furthermore, the salient activities as they relate to culture were grouped to form categories (Elo & Kyngäs, 2008) thus presented in Table 1.

The tape-recorded interview responses was transcribed verbatim and translated in English by the researcher, constant comparison analysis (Leech, 2007) was as well used to analyse the data obtained from interview for descriptive comments about the cultural practices (Elo & Kyngäs, 2008).

8. Result and Discussion

The results of the study shows that four themes generated from the observation are the patients’ cultural attributes (Spiritualism, Family solidarity Language/Communication and Dietry), as shown in Table 1, suggesting that subjects in the study area cannot be disconnected from their culture even if they find themselves in a formal setting.

Table 1: Content Analysis of Observation

<table>
<thead>
<tr>
<th>s/n</th>
<th>Codes</th>
<th>Time</th>
<th>Location</th>
<th>Category</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congregational Prayer</td>
<td>During Five daily prayers</td>
<td>Bedside</td>
<td>Spiritual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual prayer</td>
<td>Helping the patient to perform his 5 daily prayers</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>End of Life supplications</td>
<td>When the sickness is critical</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spiritual prayer(Christians)</td>
<td>During visiting hours</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>counselling</td>
<td>When necessary</td>
<td>Bedside</td>
<td>Family Solidarity</td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td>Receiving visitors</td>
<td>During visiting hours</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social interaction</td>
<td>When there is need</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keeping patient in company</td>
<td>All the time</td>
<td>Bedside</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Interpretation</td>
<td>During ward round</td>
<td>Bedside</td>
<td>Language</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Feeding</td>
<td>When there is need</td>
<td>Bedside</td>
<td>Dietary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laundry</td>
<td>Usually in the morning</td>
<td>Camp</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>cooking</td>
<td>When there is need</td>
<td>Camp</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This agrees with the perception of some of the patients when asked about the attributes. All of the patients interviewed expressed their total commitment to their spiritual faith, one of them have this to say;

“We believe spiritually that drug treats but prayer heals”

At so many times patients and their families do create a forum mostly by the bedside for discussions among themselves when they are bored, “It provides me psychological comfort when I feel tired and lonely”

This provides them a form distraction to patients who was observed to be surrounded by family and friends most of the time responded that; “I always feel at home when surrounded by my family, it gives me strength and raises my hope”

As for a patient who was observed being assisted by a family member by his bedside in communicating with the healthcare personnel during ward round expressed that he neither understand English nor the commonly spoken language.

“I find it difficult in expressing myself to them, as such my brother assist me in telling them what they need to know and inform me of what they say”.

Furthermore, the result of both the observation and interview suggest that the presence of the patients’ family throughout the hospitalisation period make a remarkable contribution to the effectiveness of the healthcare delivery even though they have not been provided for in the hospital setting.

Food provision to the patients has been observed to be a serious challenge. The patients mostly seems to be more interested in the food prepared supplied from home rather than the one supplied by the hospital,

“I prefer to have something to eat any time I want by the bedside, but the hospital food is not readily available all the time”

Though cooking is not allowed in the hospital ward vicinity but yet a group of patients relatives were observed cooking food at one corner of the ward backyard. One of them has this to say;

“I have no relation that can provide me food from home and I don’t have money to be buying food all the time, but with little money I can buy ingredients that can last long”.

9. Implication for Design

Despite the formality of the hospital ward setting, it is obvious that the people cannot be disconnected from their informal way of living. This suggest that, hospital design in Nigeria has to be configured to provide for such cultural practices in order to meet the user satisfaction and improve restoration.

The major design challenge of the ward setting imposed by such cultural practices is more of spatial in nature, the ward is accommodating patients and their families in a space meant for patients only thereby overstretching facilities meant for the patients. However, providing spaces for social interaction within the hospital ward will go a long way in providing convenience to both staff, Patients and their families.

Owing to the important role played by the patient’s family during hospitalisation, making convenient provision for their stay with their patients will go a long way in ensuring orderliness of the ward spaces and practices. Convenient ancillary facilities need to be provided within the adjacencies of the ward to cater for their laundry and cooking activities.

Introducing and improving such facilities will ensure user satisfaction that will conceptualize the hospital setting as a home place for the patient rather than being a setting of scientific enquiry disconnected from everyday life.
10. Reference


