A CRITIC OF MATERNAL MORTALITY REDUCTION EFFORTS IN NIGERIA

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ABSTRACT

Context: Maternal mortality in Nigeria is high and occurs from direct and indirect medical causes together with non-medical causes which include socio-economic, religious, cultural and legal factors, reproductive health factors and health systems/health services factors. Government and Non-Governmental Organizations have over the years expended efforts towards the reversal of Nigerian's unacceptably high maternal mortality trends.

Objective: This review examines major polices and programmes targeted at maternal mortality reduction in Nigeria as well as their possible outcome if any, identifies gaps attendant on these efforts, and suggests the way forward towards a sustainable maternal mortality reduction in Nigeria.

Maternal mortality reduction activities in Nigeria: Majority of these activities have been characterized by inherent poor design, lack of co-ordination with existing maternal health services and absence of sustainability mechanism, with an overall poor outcome. Amongst major maternal mortality reduction activities in Nigeria includes: Life Saving Skills (LSS) introduced by the American College of Midwifery in 1980 for emergency obstetrics care and ultimately supported by UNICEF and WHO; White Ribbon Alliance developed by Centre for Development and Population Activities (CEDPA) in late 1990s; Prevention of Maternal Mortality Project (PMM) introduced by Columbia University in 1987 using funds from Carnegie corporation; The Making Pregnancy Safe Initiative introduced by WHO in 2000; Women and Child Friendly Health Services Initiative established in 2000 by the former Nigerian's First Lady — Late Mrs. Stella Obasanjo; United Nation Millennium Development Goals (MDGs) initiated in 2000; Women Sexual and Reproductive Rights Project initiated in 2002 by the International Federation of Obstetrics and Gynecology (FIGO) in partnership with Society of Obstetrics and Gynecology of Nigeria (SOGON) using funds obtained from Packard Foundation. Others include: Mentoring for Post Abortion Care (PAC) Services Delivery initiated by Ipas in 2007; The Integrated Maternal, New born and Child Health Strategy Initiative of the Federal Ministry of Health also initiated in 2007; and the Midwives Services Scheme (MSS) initiated by the Federal Government in 2009.

Gaps identified to militate against maternal mortality reduction efforts include discontinuity and disconnect in government policies and programmes; legislation and other services emanating from change in government or between the executive and legislature within the same government; poor leadership of the health sector by the health ministries; poor coordination of maternal mortality reduction activities; poor development of human resources and health service infrastructure; inadequate funding of the health system, particularly of maternal health services; poor record keeping; and insufficient social mobilization activities.

Recommendation and conclusion: Improving maternal mortality reduction efforts in Nigeria involves overhauling of the health system and services to render quality and affordable health care; adequate budgetary allocation and fund release for maternal health services; human resources development through recruitments, training and retraining; ensuring prudence in the development and siting of maternal health service infrastructure; ensuring program continuity between governments, and policy/legislative connect within government; developing effective record keeping protocol for maternal health services; establishing effective social mobilization outfits and harnessing health sector partnership for funding and other health services.

Keywords: Critic; Maternal mortality reduction efforts; Nigeria

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INTRODUCTION:

The World Health Organization defines maternal mortality as a death of a woman while pregnant or within 42 days of a termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental and incidental causes.[1] Approximately 515,000 maternal deaths occur annually the world over with morbidity in as high as 50 million women. About 99 % of the maternal deaths occur in developing countries.[2] Nigeria with a population of 140 million is the most populous country in Africa. Nigerians population constitutes 1.2 % of the overalls world's population, unfortunately Nigeria harbors as high as 59,000 maternal deaths annually accounting for more than 10 % of the world's maternal death.[3, 4] Maternal mortality statistics in Nigeria from national surveys have shown wide variations, believed to be related to logistics and technical difficulties. The United Nations Population Fund's (UNFPA) 2002 version of the State of the World's Population Report indicated a maternal mortality ratio figure of 1,100 deaths per 100,000 live births.[5] A 2003 report from the Federal Ministry of Health indicates maternal mortality ratio of 948 per 100,000 live birth with a range of 339 to 1,716 per 100,000 live birth, while the most recent 2008 Nigerian Demographic and Health Survey indicates a reduction in Nigeria's maternal mortality ratio to 545 per 100,000 live births.[6,7] Among the causes of maternal mortality in Nigeria includes direct and indirect medical, and non-medical causes. The direct medical causes of maternal mortality are shown in Table 1.

Table 1: Direct medical causes of maternal mortality in Nigeria

Hemorrhage	23 %
Sepsis	17
Malaria	11 %
Anaemia	11 %
Abortion	11 %
Hypertensive disorders/Eclampsia	11 %
Obstructed Labour	11 %
Others including Ectopic pregnancy, Embolism and Anesthesia related risks	5 %

Indirect medical causes of maternal mortality refer to problems that may have been either pre-existing but have become aggravated by the pregnancy or co-existing with the pregnancy for example malnutrition, cardiac failure, tuberculosis, sexually transmitted infections, gender based violence, etc. They constitute 20 % of the medical causes of maternal mortality.[8] Non medical causes essentially refer to factors that influence pregnancy and delivery outcome thereby increasing maternal mortality. They include social, economic, cultural, religious and legal factors, reproductive health factors, and health services and health systems factors.

Socio-cultural, economic, and legal factors to a considerable extent influence acceptability, accessibility, and utilization of health facilities mainly through constraint that impede women's ability to make decisions concerning their health care. Patriarchy promotes low status of women often pronounced in education, income, work-burden and several other forms of gender inequality. Early marriage and other traditional harmful practices all constitute culture-imbued women's reproductive right infringements that influence access to reproductive health care and promote maternal mortality.

Poverty has profound influence on the health of the mother and child in Nigeria, which impact tremendously on the overall quality of life. Poor mothers tend to have poor nutrition increasing their susceptibility to anaemia and infection with overall poor pregnancy outcome. Furthermore they are seldom able to afford patronage to hospitals or orthodox maternal health services and often times resort to substandard health care. Studies conducted in selected area of Benue State show that in spite of the preference of most people to receiving treatment from orthodox health facilities, most of the poor, in fact resort to receiving treatment from patent medicine stores, native medicine men, and spiritual homes on account of their inability to afford the cost of health services from orthodox facilities.[9]

Education plays a prominent role in maternal health outcome in Nigeria. Report from the National Demographic and Health Survey (NDHS) of 2003 shows that whereas 60 % of mothers with no education relied on unskilled

attendants during delivery, only 9 % of mothers with higher education did so.[10]

Religion has been identified as a major influence to maternal health seeking behaviour of Nigerian women evident from the role of the prayer houses in the south and the Pudar system in the north. The Muslim Pudar system which is believed to have become integrated into the culture of the people discourages the patronage of pregnant women to orthodox health facilities, so as to prevent them from being attended to, by male staff. They are encouraged therefore to be attended to by female traditional birth attendants who apart from paying strict attention to cultural imperative also seize the available opportunity to perform religious rites.[11, 12]

Abortion and its complications constitutes a major cause of maternal deaths in Nigeria — perhaps much more than usually reported since records on clandestine abortions are not available. Center for Reproductive Rights reported that approximately 34,000 maternal deaths occur annually in Nigeria from abortion and its complications.[3, 4] Unsafe abortion occur as a result of restrictive abortion laws in Nigeria which drive abortion services underground being performed predominantly by quacks with resultant complications and death.[13, 14]

Reproductive health factor interplay with other variables to impact on maternal health outcome, poor antenatal care-seeking behavior of Nigerian women with low delivery rate in orthodox health facilities; low contraceptive prevalence rate due to poor access, and high unmet need for family planning; high teenage pregnancies compounded by lack of adolescent health friendly services and restrictive abortion laws, all constitutes reproductive health factors that in the long run increased maternal mortality in Nigeria.[7, 15, 16, 17]

Health services and health systems factor play no less a prominent role in maternal health outcome in Nigeria than the other aforementioned factors. The NDHS survey of 2003 showed that the proportion of Nigerians with access to health care services was put at 56.5 %. Only approximately half (49.8 %) of primary health care facilities in the country provide antenatal care while 42.9 % provide delivery services.[15, 18, 19] Emergency obstetrics care is poorly developed in Nigeria. Studies conducted by the Federal Ministry of Health and UNFPA in 2003 indicated only one State out of 12 studied met the minimum criteria of the four Basic Emergency Obstetrics care facility per 500,000 population.[20] Human resources constitute an essential element of maternal health services. Human resources availability and development in Nigeria is adjudged to be poor. The NDHS of 2003 reported that over 40 % of the 6,219 births in five years preceding the survey had no trained assistance during delivery. As high as 58.2 % of Primary Health Care facilities offering both midwifery and delivery services have been shown in a recent study to have no midwife while 17 % had neither midwife nor Senior Community Health Extension Worker (SCHEW).[15] To date the number of Medical Doctors trained on Expanded Life Saving Skill (ELSS) is about 10-15 %, while only approximately 20-25 % of nurse/midwives are trained on Life Saving Skills (LSS). In general health services in Nigeria particularly in the public health sector are poorly patronized. Dilapidating health infrastructure, lack of equipments, and drug stock out combined with unfriendly attitude of health workers, together with their reduced technical competence which affects the quality of service, all operate in concert to render most public health facilities unattractive and therefore poorly patronized.[15, 21, 22, 23, 24] Perhaps foremost among factors influencing maternal health services at health systems level in Nigeria includes inadequate funding of the health sector, poor budget release and budget implementation which invariably affects all facets of maternal health services.

Nigeria health expenditure as a percentage of the gross domestic product has been given to be 0.2 percent over the period between1990-1998. This figure is considered to be low when compared with the World Bank's reported average of 2.6 % for sub-Saharan Africa from 1990-1996.[25] The overall performance of the Nigerians health system has been adjudged to be deplorable. The 2000 WHO Global rating of health system performance ranked Nigeria 187th out of 191 countries accessed.[26]

Given the maternal health services scenario, Nigerian government and its benefactors alike have over the years striven to reverse the un-salutary maternal mortality and reproductive

health statistics of the country, and this is expected to have yielded positive result.
This review examines major polices and programmes targeted at maternal mortality reduction in Nigeria as well as their possible outcome if any, identifies gaps attendant on these efforts, and suggests the way forward towards a sustainable maternal mortality reduction in Nigeria.

BRIEF REVIEW OF MAJOR MATERNAL MORTALITY REDUCTION ACTIVITIES IN NIGERIA

Over the past three decades several maternal mortality measures have been carried out in Nigeria by both government and Non-Governmental Organizations (NGOs) in the form of either social mobilization efforts or frank maternal mortality reduction programmes. Unfortunately those activities have not translated into the desired reduction of maternal mortality in Nigeria due to the inherent poor design, lack of co-ordination with existing maternal health services and absence of sustainability mechanism. Furthermore community participation and intersectoral collaboration mechanism are often lacking in the design and in the implementation of most of those programmes. Many of the programmes are also donor dependent and therefore short-lived, virtually extinguishing with the termination of donor fund.

Social mobilization through advocacy have been recognized as an effective instrument for the propagation and implementation of reproductive health activities and this has been eminently highlighted in the Nigeria's National Reproductive Health Strategic Framework and Plan (2002-2006).[27] Social mobilization committee has been established in many States of the Federation. It is of multi-disciplinary composition and is usually domicile in the Ministry of Health, where its use for reproductive health activities is often needed. Unfortunately social mobilization committees have not proven strong and committed enough to make any meaningful impact into maternal mortality reduction in Nigeria, for one reason or the other. At national level there is virtually no social mobilization framework and this constitutes a major hindrance to a nationwide maternal mortality reduction efforts. Although National Orientation Agency (NOA) exists, its orientation and advocacy efforts have in the past been largely political. It is only recently that NOA has started participating in health sector mobilization — particularly those that are ad-hoc such as National Immunization Day.

Safe motherhood committees have been established especially in States with an aim of, amongst other things, mobilizing communities towards safe motherhood activities. Apart from the Safe Motherhood Day Celebration, sponsored by UNICEF and carried out once every year there is virtually no recognizable safe motherhood mobilization activity witnessed in a national scene, and supported by government. Until recently when a number of States in Nigeria have commenced free maternal health services to meet up with the demands of Millennium Development Goals (MDGs,) there had been no government focus on maternal mortality reduction efforts targeted at the poor masses of Nigeria who had had to depend on out-of-pocket expenses to cater for their health care needs, maternal health care inclusive. Amongst some of the social mobilization and maternal mortality reduction programmes in Nigeria include the following:

Life Saving Skills (LSS) Training

The Life Saving Skills Training programme was developed by the American College of Midwifery and introduced into Nigeria in the late 1980s under the Mother Care Project. The training was essentially aimed at impacting necessary emergency obstetrics care skills to midwives while providing them with requisite complimentary equipments and other obstetrics emergency service logistics. In 1994 USAID stopped funding of LSS in Nigeria following American de-certification of the country due to political crisis. LSS training had to be taken over by UNFPA, which it undertook in its 12 focal States. Later UNICEF also established LSS training in some other States while WHO followed suit in some Local Government Areas (LGAs). Expanded Life Saving Skills Initiatives (ELSSI) was later introduced to impact

emergency obstetrics care skill to Medical Doctors while the Modified Life Saving Skills (MLSS) was introduced for the Community Health Extension Workers. These life saving skills programme have therefore identified and apparently taken care of skilled training needs for emergency obstetrics care for the cadres of health professionals involved in the Safe Motherhood activities. Obvious difficulties undoubtedly occur, inherent in these professionals that make these training incomplete and therefore seemingly inadequate. There is no doubt however that these skills acquisition training will improve emergency obstetrics care services and engender an overall reduction in maternal mortality.

The White Ribbon Alliance

This is a maternal mortality reduction initiative developed by the Centre for Development and Population Activities (CEDPA) in the late 1990s, with essential aim of mobilizing development partners, governments, and other Non-Governmental Organizations (NGOs) into safe motherhood activities. The alliance however did not make the required impact being characterized by poor co-ordination and lack of cohesion. It is presently in a state of coma.

Prevention of Maternal Mortality (PMM) Projects

This project was initiated in 1987 by Columbia University supported with funds from Carnegie Corporation. The project focused on reducing maternal mortality employing local multi-disciplinary team in various communities and technical support from overseas partners. The project targeted at addressing the various categories of delays to access of emergency obstetrics care service. Seven centres participated in the project — Benin, Calabar, Enugu, Ilorin, Lagos, Sokoto, and Zaria. The project which was apparently promising eventually waned and fizzled out following the termination of donor support.

Making Pregnancy Safer (MPS) Programme

The Making Pregnancy Safer Initiative was introduced by WHO in 2000. It is a health sector response aimed at facilitating access to skilled obstetrics care. The initiative essentially employed advocacy; social mobilization of community members; designation of centers as basic emergency obstetrics care and comprehensive emergency obstetrics care; and equipping such centres to meet with the requisite standard; training of skilled birth personnel on life saving skills; strengthening referral system; establishing an effective monitoring and supervision machinery and ensuring overall community participation. The Making Pregnancy Safe Initiative appears attractive and the design has been adopted for the Canadian International Development Agency (CIDA)/UNFPA supported emergency obstetrics care project undertaken in three North Western States of Katsina, Kebbi, and Sokoto in 2006/2007 and in the six States of Anambra, Edo, Osun , Bauchi, Borno, and Plateau, started 2008 to 2009.

Women and Child Friendly Health Services

This initiative was established in 2000 by the former Nigerian's First Lady — Late Mrs. Stella Obasanjo. The initiative cuts across all aspects of maternal health and sets standards of practice of care that ensured quality and preserve the dignity and rights of mothers and children. It also provided for the motivation of health workers and integration of services to optimize results.

Women Sexual and Reproductive Rights Project (WOSRRIP)

This project was initiated in 2002 by the International Federation of Obstetrics and Gynecology (FIGO), using funds obtained from Packard Foundation, and working with Society of Obstetrics and Gynecology of Nigeria (SOGON). The project focused on three major areas viz; Advocacy to Obstetrics and Gynaecology professionals on the sexual and reproductive rights of women, on the need to protect and promote them; development of a human right based Code of Ethics to guide health practitioners caring for women and incorporating into the curriculum of medical education; advocacy on two key sexual and reproductive right failings of women in Nigeria — female genital mutilation and unsafe motherhood. The FIGO/WOSRRIP project was followed in 2007 by a similar maternal and newborn health services project — Save the Mother and New Born Project (SMNH) being conducted simultaneously in three centres

in Zaria, Nnewi, and Benin City. This project is born of the understanding that maternal and new born mortalities and morbidities are closely related and should be tackled in a holistic and integrated manner.

The Integrated Maternal, New Born and Child Health Strategy

This initiative of the Federal Ministry of Health represents Nigerians response to the global partnership for maternal, new born and child health. It is a high impact cost effective intervention strategy that addresses maternal, new born and child health services in a holistic rather than the hitherto vertical approach. The strategy addresses 90 % of the six conditions responsible for maternal deaths as well as the most common conditions responsible for over 90 % of under-5 mortalities. All stakeholders in maternal mortality reduction including all the States of the Federation are expected to be carried along in the project.

Mentoring for Post Abortion Care (PAC) Services Delivery

Ipas in 2007 initiated the mentoring for Post Abortion Care (PAC) services delivering projects in six States of the Federation together with the Federal Capital Territory. This is a trainee follow-up project conducted in six health facilities in each of the States focusing on the reduction of maternal mortality and morbidity from abortion and its complications. This project provided for profuse interaction and mentoring between health care providers trained on PAC services, the mentees and their trainer, the mentor.

Millennium Development Goals (MDGs)

The Millennium Development Goals initiated in 2000 is a United Nations (UN) response to poverty eradication giving right to sustainable economic development of nations. MDGs 5 and 4 are specific for the mother and infant respectively. Furtherance to the promotion of the MDG, the Nigerian government initiated the National Economic Empowerment and Development Strategy (NEEDS) which also addresses reproductive health and safe motherhood issues as a requisite to national development. The Nigerian Presidency established an MDG unit, overseen by a Special Adviser. A considerable amount of the funds accruing from the Nigerian debt relief was in fact channeled into the actualization of the MDGs and specifically towards maternal mortality reduction effort.

Midwives Services Scheme (MSS)

The MSS was initiated by the Federal Government in 2009 and represents a large scale nationwide maternal mortality reduction program in Nigeria. The initiative seeks to provide an emergency stop gap to the human resource shortage of skilled attendance at birth within our primary health care system, mobilizing unemployed and retired but able midwives for deployment to health facilities in rural communities. The purpose of the scheme was to increase skilled attendance at birth so as to facilitate reduction in maternal, newborn and child mortality and morbidity. The scheme involved the training of the participating midwives on Life Saving Skills (LSS) and Integrated Management of Childhood Illnesses (IMCI), and building their capacity towards effective community partnership that will encourage community ownership of the program. Federal government is funding the scheme through the National Primary Health Care Development Agency, for the first two years from first quarter of 2009 to 2011. Subsequently States and LGAs are expected to take over from the third year for sustainability.

IDENTIFIED GAPS IN MATERNAL MORTALITY REDUCTION EFFORT IN NIGERIA

The numerous effort at reducing maternal mortality in Nigeria over the years have yielded little or no result having failed to record any appreciable impact in lowering the maternal mortality ratio of the country. Government at all levels — Federal, State, and Local government have a major chunk of blame in its inability to operate a health system and health sector that will be enabling enough to achieve a sustainable maternal mortality reduction. Government action or inactions in health care in respect of budgetary allocation — release and implementation, health service delivery and health infrastructural development in general, of which maternal health services constitute a major part, amount to a near total abdication of this very important social

responsibility. Discontinuity and disconnect in government policies and programmes, legislation and other services have virtually become common place as successive government ignore or out rightly jettison health programmes initiated by their predecessor irrespective of how laudable those programmes may have been, to the utter dismay, embarrassment, and ultimate frustration of the people.

The Ministry of Health, the apex custodian of health services, has continually and consistently demonstrated its inability to provide the leadership and direction needed to move the health sector to a higher level either through the ineptitude, insincerity or incompetence of its staff or a betrayal of an unpardonable hypocrisy or lip-service, which prohibit it from adopting a firm and positive stand on the presentation of the nations true health requirements and needs to government. It is possible therefore that government may have shirked and goofed on its health care responsibilities to the people, thanks to the misguidance of its Ministry of Health.

Maternal mortality reduction activities in Nigeria can best be described as uncoordinated dominantly donor-driven. It is akin to labor in a pregnant uterus riddled with uterine fibroid, where the Ministry of Health representing the utero-tubal pace makers generates action potentials that seem to be counteracted by several other active potentials emanating from various donor funding agencies representing ectopic pace-makers. The result of this is total incoordination.

Even within government, disconnect has been observed between legislative and executive arm and between them and the people such that legislation related to maternal mortality reduction passed and sign into law may neither be disseminated to the public nor be implemented by the executives.

Human resources development which includes the training of skilled personnel, their recruitment and the re-training of existing ones have often not be taken into account in the planning and implementation of maternal mortality reduction effort. No meaningful maternal mortality reduction can be achieved without the use of skilled birth personnel.

The development of health service infrastructure has been characterized by political distortion rather than community needs and desire. It is therefore possible to find new health centres constructed in undesirable areas in-accessible, unacceptable and therefore not patronized by the members of the community. Some of the facilities are even put up without any budget support for equipments, drugs, and health personnel.

Funding of maternal health services deserves special mention since it constitutes an inevitable requirement towards the sustainable reduction of maternal mortality. For now little can be said of government funding of maternal health services whether at national, state, or local government level. It seems as if the little funding that goes into maternal health services in the country comes solely from donor funding agencies. This funding is often short lived, and is disbursed and utilized only at the whims and caprices of the donor agencies which may sometimes run discordant to the maternal health priorities of the nation or state. Where government has expended fund on health services most of this has gone into infrastructural development believed to attract advantages to the politicians and government functionaries, and personnel emoluments, rather than the health services that will be expected to impact on the people.

Funding partnerships such as from health insurance schemes at community level have not been explored or exploited for maternal mortality reduction effort, but for in one or two States of the Federation.

Health sector partnership such as private-public partnership, public-public partnership, and community-public partnership still remains to be harnessed for maternal health services in the country.

Record keeping in maternal care still needs to be effectively developed to provide the necessary accurate data for a more effective maternal health service planning and programming.

Social mobilization as an instrument of maternal mortality reduction has not been harnessed adequately in Nigeria. A lot still needs to be done to improve social mobilization effort and advocacy to communities on access to orthodox maternal health service facilities which have been found to be lacking in several communities all over the country.

RECOMMENDATIONS AND CONCLUSION

Health seeking behavior of the people can change for the better only when orthodox health services whether at private or public level is made attractive and affordable to the people through ensuring an enabling environment; improving the quality of maternal health services delivery through the provision of modern equipments and adequate supply of drugs; making services affordable through subsidies and free services; improving the inter personal relationship and skills of health workers through appropriate inclusion of such skills into the curriculum of medical and midwifery student while ensuring the training and retraining of servicing skilled birth attendants.

It has become absolutely necessary to review and overhaul the health system structure of the country to shed off ambiguities and undesirable overlaps.

Budgetary allocation to health at all governmental levels should be reviewed and beefed up to conform with the recommended quota by WHO for developing countries, and furthermore release of budgeted fund should not only be ensured but program and project implementation, supervision and monitoring, adequately ensured, in particular funding of maternal health services should be reviewed and redirected to provide for people's need. Continuity of health programmes and project commenced during the tenure of one government administration should be ensured during the tenure of ensuing government. Within the government adequate connect should be ensured between legislation and the executives so that health related bills passed by the legislature can be disseminated and implemented by the executives. It is necessary to establish at all levels of government a continuity office under the office of the Chief Executive to screen and identify laudable programmes of a previous regime that should be continued by an index administration.

The activities of donor funding agencies laudable as they may seem, need to be better coordinated to prevent duplications and ensure better results. Donor funding should be placed in “one basket” and funds channeled to areas according to priority needs.

The plan of activities of Health Ministries should incorporate training and retraining of human resources as well as the recruitment of trained personnel as the need arises.

Health infrastructural development should be tailored towards community needs and desires to ensure adequate community patronage.

It is necessary to establish a uniform and effective record keeping protocol on maternal health services throughout the country to capture the events in maternal health — a prerequisite to effective planning and action.

Finally the need to establish a health sector funding partnership has become inevitable at all levels. To begin with, the National Health Insurance Scheme should expedite action towards keying in maternal health services at community level into its programmes.

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