COMBATING MATERNAL MORTALITY IN NIGERIA THROUGH COMBINED AND SUSTAINABLE REGULATORY APPROACH*

Abstract

Maternal mortality is the death of a woman during pregnancy or labour as a result of pregnancy within forty-two days after delivery or abortion. Death occurring after this time is no longer ensuing from pregnancy. The world is putting a lot of efforts at reducing this menace and is recording a number of successes. But worrisomely, Nigeria still has the second highest rate of maternal death (globally) after India. Factors that have been identified as causing it ranges from poverty, ignorance, illiteracy, religion, socio-cultural and political causes. Despite the seemingly active interventions of both the medical institution and government in Nigeria, the battle is far from being won as indicated by the existing data. There have been a number of socio-medical programmes embarked upon by various levels of government in Nigeria, but because of non-sustainability and non-synthesised approaches (through combined regulations and policies), each effort often crumbles as a new government and political regime comes into power. This paper identifies and classifies the diverse factors responsible for high incidence of maternal death in Nigeria. Proper and clear-cut classification by this paper helps in presenting a clearer picture of the causes and proffering practical and attainable solutions. The workable answer lies in the combination of efforts rather than just combating the various causative factors disjointedly. Efforts can only be combined if there are sustainable regulations and policies that will outlive each political regime. A major contribution of this paper lies in the fact that the paper urges for the creation of holistic and combined regulatory/policy structure to tackle the problem which may not necessarily be medical or socio-cultural alone. This include educational polices, financial and budgetary policies, as well as health policies. Using the doctrinal method, this research uses primarily, works from previous authors in this area, books, articles and academic material are all accessed. Other forms of secondary data such as reports through news and newspapers are also used.

Keywords: Maternal mortality, Regulatory approach, Combined and sustainable, Nigeria

1. Introduction

Issue of maternal health is almost an over flogged issue in Nigeria; this theme occurs in almost every medical and social discussion. A lot of workshops and seminars have been organised to discuss and proffer solutions to this issue. Nonetheless, the problem is still persistent in our nation with its venom as harsh as it was in days of yore. Pregnancy and childbirth ought to be a thing of joyful celebration but this appears not to be the case in Nigeria as pregnancy comes with a lot of fear and apprehensions because the safety of either the mother or the unborn is unknown and uncertain. This fear is not based on assumption or imagination it is rather based on empirical facts and figures. Nigeria is recorded to have the second highest rate of maternal death in the world.[1] There have been a number of efforts at reducing the rate of death in Nigeria by both local and international bodies.[2] In fact there have been global commitments at reducing this menace, thus the inclusion of maternal health as the fifth goal of the MDGs. However, the matter of maternal death goes beyond health issues, it depicts the eye of the society to womanhood and the place of gender in the society. Therefore addressing this problem requires a holistic approach that will tackle not only medical but the socio-cultural, religious and psychological causes.

This paper therefore aims at methodically analysing the causes of maternal death, through a different classification style. It will then go further to explore the possibility of attaining reduction through the creation of answers to each of the factors that make the rate high. The primary contribution of this paper

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[1] Ogunjimi L. Olusegun I, Thomas R. and Ikorok M. 'Curbing maternal and child mortality: The Nigerian experience' *International Journal of Nursing and Midwifery* Vol. 4(3), pp. 33-39, April 2012.

[2] L. Pearson, L. deBernis, R. Shoo , 'Averting Maternal Death and Disability, Maternal Death Review in Africa' *International Journal of Gynecology and Obstetrics* 106 (2009) 89–94.

to the existing discussion lies in the recommended means of combating it, which is a holistic and practical approach that traverses the entire length of human endeavour. It is not making a general or sweeping recommendation rather it gives recommendation based on each specific causative factor identified. However, the paper start by examining the menace called maternal mortality, and then moves to discuss the causes through its classification.

2. Maternal Mortality

Maternal mortality is the same thing as maternal death and has been defined by so many authors and organisations in times past. It has been defined by The International Federation of Gynaecologist and Obstetricians as death occurring during pregnancy or labour as a consequence of pregnancy within forty two day after (42) after delivery or abortion.[3] The World Health Organisation (WHO) equally defines Maternal Mortality as the death of a woman while pregnant or within 42 days of the termination of the pregnancy, (through birth, miscarriage or abortion) irrespective of the duration and site of such pregnancy, from any cause related or aggravated by the pregnancy or its management.[4] Thus accidental or incidental causes to pregnancy are not included in this. Another author defines it as the death of female associated with pregnancy, labour and *puerperium.*[5] Yet, another author defines maternal mortality as the death of mothers caused by disease and other conditions related to pregnancy and childbirth.[6] Essentially, maternal mortality is death of a woman due to the state of her pregnancy or related facts to the pregnancy, during the pregnancy, birth or a close period after birth. Death could also occur even if the pregnancy did not result into birth, that is, irrespective of how the pregnancy terminated. The high incidence of maternal death has grave implications not only for the family or the community but also the nation at large.[7] Safe motherhood is an index of a nation's development or otherwise. Maternal mortality rate for every year is the number of deaths ascribed to pregnancy and childbirth per 1000 registered total birth.[8] The implication of this is that if death occurs more than 42 days after the termination of such pregnancy then it is no longer classified as maternal mortality.

Maternal Mortality is a major health challenge globally, more than one woman die every minute from pregnancy and child birth, about 585,000 die every year; it is an indicator of disparity and inequality between men and women and it signals the place of women in society and their access to social and to economic opportunities.[9] A number of the cases of maternal mortality are preventable. 'It is estimated that 74% of maternal deaths could be averted or prevented if all women have access to the interventions for preventing or treating pregnancy and birth complications to the Challenges'.[10] This type of death is a complex challenge globally based on many factors; the death itself is a major challenge while the problem of neglect, inadequate information and data collation methods pose a bigger challenge. Nations with the highest level of mortality rarely have good coverage or reporting of vital events such as births, sickness and deaths, even countries with relatively complete vital registration may have less than adequate attribution of causes of death.[11] It is essential to have accurate information and record because knowing the timing and cause of death in relation to pregnancy is material and key to classification of the cause of death whether indeed it can be deemed as maternal mortality or not.

[3] Onyenenam C.T. Factors Responsible for High Infant and Maternal Mortality in Nigeria : A Case Study of Abakaliki in Ebonyi State (2013) http://articlesng.com/factors-responsible-high-infant-maternal-mortality-nigeria/ (Accessed 30th June, 2020).

[4] WHO - http://www.who.int/healthinfo/statistics/indmaternalmortality/en/ (Accessed 1st August, 2020)

[5] Yaukey, D. & Anderson, D. L. (2001). *Demography: the Study of Human Population.* (2 Ed.), Wave Land Press Inc.

[6] Supra note 3. See also Ronsmans C., Vanneste A. M. Chakraborty J. and Ginneken J.V. 'A comparison of three verbal autopsy methods to ascertain levels and causes of maternal deaths in Matlab, Bangladesh' *Int. J Epidemiol*. (1998) 27(4)):660-666.

[7] *ibid*.

[8] Supra note 4

[9] World Health Organisation, UNICEF, UNFPA and The World Bank 'Trends in Maternal Mortality: 1990 to 2008 (2010), available at http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf. (Accessed 1st August 2020).

[10] Wagstaff A. and Claeson M. *The Millennium Development Goals for health: Rising to the Challenges.* The International Bank for Reconstruction and Development/ World Bank 2004.

[11] Carla AbouZahr 'Global burden of maternal death and disability' *Oxford Journals Medicine & Health British Medical Bulletin* Volume 67, Issue 1 Pp. 1-11. See also Adebowale S. A.; Fagbamigbe F. A.; and Bamgboye E. A., 'Rural-Urban Differential In Maternal Mortality Estimate In Nigeria, Sub-Saharan Africa'. *Journal of Medical and Applied Biosciences* Volume 2, September 2010.

Attaining and maintaining reduction in the maternal death rate has become an issue in the front burner globally because it is a reproductive right which governments have been facing increasing obligation to protect. According to CEDAW's General Recommendation and CESCR's General Comment on women's health issue,[12] every Nation has three kinds of obligations for the implementation of human rights namely the:[13] obligation to *respect* rights, obligation to *protect* rights, and obligation to *fulfil* rights. The implication of the above is that each nation is required to refrain from interference with rights, prevent actively the violation of such rights by another person and to also take appropriate steps towards a full realisation of such right.[14] Para 14 of CEDAW General Recommendations on Women and Health emphasised this further when it stated that: The duty to fulfil rights places an obligation on States Parties to take appropriate legislative, judicial, administrative and budgetary, economic and other measures to the maximum extend of their available resources to ensure that women realise their rights to health care.

Maternal Mortality in Nigeria

Nigeria has one of the highest numbers of maternal mortality and is ranked second in the world behind India with the maternal mortality ratio (MMR) being about 81 times worse than in the industrialised countries and accounts for about 13 percent of global maternal death.[15] India is estimated to have136,000, followed by Nigeria with 37,000, Pakistan -26,000, Democratic Republic of Congo and Ethiopia -24,000 each, the United Republic of Tanzania 21,000, Afghanistan 20,000, Bangladesh 16,000, Angola, China and Kenya with 11,000 each, Indonesia and Uganda - 10,000 each. These 13 countries account for 67% of all maternal death globally. An estimated 56,000 women die each year as a result of pregnancy related causes.[16] Nigeria forms part of the six countries that collectively accounted for over 50% of all global maternal death.[17] She ranked eighth in terms of maternal mortality ratio in Sub-Sahara Africa, just behind Angola, Chad, Liberia, Niger, Rwanda, Sierra Leone and Somalia.[18] Though Nigeria has put in a lot of intervention efforts at reducing maternal death through the primary health care which ensures that as much as possible women are healthy throughout pregnancy and childbirth and that they recover fully from the effect of pregnancy,[19] however, when mortality rates are viewed globally, approximately 1 in every 9 maternal deaths occurs in Nigeria.[20] This high incidence therefore calls for serious concerns and actions. But before solutions can be proffered it is essential that the real cause be identified and properly outlined so that the country will not embark on a futile journey.

3. Causes of Maternal Mortality

According to World Health Organisation, maternal death is divided into two groups, the direct and indirect obstetric death. Direct obstetric deaths are those ensuing from obstetric complications of the pregnant state (pregnancy, labour and the *puerperium*); from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. The other one is the indirect

[12] CEDAW's General Recommendation No. 24 Women and Health (Article 12) (Twentieth session, 1999) Contained in document A/54/38/Rev.1, chapter I. See also CESCR General Comment No. 12: The Right to Adequate Food (Art. 11) Adopted at the Twentieth Session of the Committee on Economic, Social and Cultural Rights, on 12 May 1999 (Contained in Document E/C.12/199/5).

[13] See Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No 24 on Women NS Health, Para 29, Feb. 2, 1999. See also the International Covenant on Economic , Social and Cultural Rights (CESCR) General Comment 14 on the Right to the highest Attainable Standard of Health , UNESCOR 2000, UN Doc. E/C. 12/2000/4. 11 August 2000.

[14] *Ibid.*

[15] July 12, 2014. ThisDay Newspaper. See also, Okonofua F. Report of the Society of Gynaecology and Obstetrics of Nigeria (SOGON 2005).

[16] Okonufua F *Maternal Mortality in Nigeria : Causes and Effect,* This Day Newspaper, p 16 March 15, 2006

[17] Adebowale S.A., Fagbamigbe F. A, and Bamgboye E. A 'Rural-Urban Differential in Maternal Mortality Estimate in Nigeria, Sub-Saharan Africa'. Journal of Medical and Applied Biosciences Volume 2, September 2010. See also Maternal Health in Nigeria: a statistical overview Maternal Health in Nigeria Statistical Overview, Global One 2015. Version 30 June 2011. Revised, 17 Aug. 2011. Revised again 26 June 2012.

[18] Akinrinola B., Sedgh G., Okonofua F. , Imarhiagbe C., Hussain R. and Wulf D. (2009) ' *Barriers to Safe Motherhood in Nigeria'* New York : Guttmacher Institute. Avalalable online at www.guttmacher p 3.

[19] Supra note 3.

[20] Doctor H.V., Bairagi R., Findley S.E., Helleringer S. and Dahiru T. 'Northern Nigeria Maternal, Newborn and Child Health Programme; Selected Analyses from Population-Based Baseline Survey' *The Open Demography Journal,* 2011, 4, 11-21. See also, UNICEF, The state of the World's Children 2009. New York: United Nation Children's Fund 2008.

obstetric death which are deaths resulting from previous existing obstetric diseases or disease that developed during pregnancy and which was not due to direct obstetric causes, but was aggravated by the physiological effects of pregnancy.[21] Over the years, there have been enormous researches in what actually causes the high incidence of maternal death in Nigeria and a number of solutions have also been submitted through those studies. However, a clear outline appears to be missing in a lot of these works. Therefore, perusing through the works of other scholars and researchers, the paper has been able to identify and clearly delineate the causes of maternal mortality in Nigeria aside from the identified existing ones . This paper will therefore not follow the usual classifications of others, but will regroup and discuss the causes in a different manner so as to create clarity for solution. It should be noted that based on the heterogeneous nature of the country, a particular cause may be prevalent in some areas of the nation more than the other areas, although there are general ones which traverse nationwide notwithstanding the region.

Medical Factor

These are ill-health and complications associated with pregnancy and childbirth or mishaps that may attend pregnancy and delivery. Some are temporary mild or severe conditions, while others are chronic or permanent conditions that persist beyond the *puerperium.*[22]. Haemorrhage is a leading cause of death; it consists of bleeding from the genital track of the woman during pregnancy, birth or after delivery (intra-partum and post-partum).[23] Though antepartum is no longer causes of maternal death in developed country, it continues to be a leading cause in developing countries like Nigeria. But postpartum is still a challenge to both developed and developing countries. The formal definition of partum haemorrhage is blood loss of 500ml or more within 24 hours after delivery and or within 42 days following delivery.[24] Puerperal Sepsis is another leading medical cause which can lead to obstetric shock or death. However, this can be curtailed with the administration of antibiotics to the patient; nevertheless, puerperal sepsis is still prevalent in developing countries and continues to be a leading cause of maternal death especially in operative deliveries and antibiotic resistant cases.[25] Others include pre-eclampsia and eclampsia (hypertensive disorders of pregnancy - HDP) which are a group of medical conditions that has to do with high blood pressure during pregnancy; it comes as proteinuria and in some causes convulsions.[26] Eclampsia is a condition that usually results from pre-eclampsia. The state consists of central nervous system seizures that leave the patient unconscious and may lead to death if untreated. Wilcox and Horney describe the condition as associated with vasospasm, pathologic vascular lesions in multiple organ system, increased platelet activation and subsequent activation of the coagulation system in the micro-vasculature.[27]

Abortion also is a leading cause of maternal death. it covers a variety of conditions that arises during early pregnancy (from ectopic pregnancy to hydatiform mole, spontaneous and induced abortion) and basically causes maternal death when it is unsafe and it leads to haemorrhage and infection particularly

[21] WHO, (2004). 'Maternal mortality in 2000: Estimate developed by WHO', UNICEF and UNFPA: Department of reproductive health and research WHO, Geneva.

[22] Mills S, Williams J.E, Wak G, Hodgson A: 'Maternal Mortality Decline in the Kassena-Nankana District of Northern Ghana'. *Matern Child Health J* 2008, 12(5):577-585.see also, Zakariah A.Y., Alexander S., Roosmalen J.V., Buekens P., Kwawukume E.Y., Frimpong P.: 'Reproductive Age Mortality Survey (RAMOS) in Accra, Ghana'. *Reproductive Health* 2009, 6(1):7.

[23] Abouzahr C. *'Antepartum and postpartum haemorrhage'. In: Murray C.J.L., Lopez A.D. (eds.)* Health Dimensions of Sex and Reproduction: the Global Burden of Sexually Transmitted Diseases, Maternal Conditions, Perinatal Disorders, and Congenital Anomalies. *Geneva: WHO,* 1998.

[24] Clinical Practice Guideline Prevention and Management of Primary Postpartum Haemorrhage Institute of Obstetricians and Gynaecologists Royal College of Physicians of Ireland and Directorate of Strategy and Clinical Programmes Health Service Executive Version 1.1 Date of publication: October 2012 Guideline No. 17 Revision date: May 2014. See also, Dolea C., AbouZahr C., Stein C. 'Global burden of maternal haemorrhage in the year 2000' Evidence and Information for Policy (EIP), World Health Organization, Geneva, July 2003.
http://www.who.int/healthinfo/statistics/bod_maternalhaemorrhage.pdf (accessed 5th August, 2020).

[25] AbouZahr C. 'Global burden of maternal death and disability' *Oxford Journals Medicine & Health British Medical Bulletin* Volume 67, Issue 1 Pp. 1-11., see also note 23 supra.

[26] *Ibid.*

[27] Wilcox A.J*., Horney L.F.,' Accuracy of spontaneous abortion recall'.* Am J Epidemiol (1984) 120*: pp.* 727*–33.*

when it is done in places where it unauthorised, unsafe or places that are not health facility.[28] Getting data on number of deaths resulting from abortion in developing countries like Nigeria may be quite difficult because voluntary or elective abortion is still illegal, thus women who seek elective abortion patronize quacks and willing medical practitioners who does it in unsafe and unhealthy situations.

Another leading cause of maternal death is obstructed labour. This occurs when the presenting part of the foetus is unable to progress into the birth canal, despite strong uterine contractions. One major cause of obstructed labour is cephalo-pelvic disproportion that is, a mismatch between the foetal head and the mother's pelvic brim.[29] When such obstruction is neglected, it results into either the death of the mother or the infant. Usually, the solution to this is the carrying out of operative procedures such as caesarean section or other forms of instrumental delivery such as forceps, vacuum, extraction or simphysiotomy.[30] A lot of complication can therefore result from neglected obstructive labour such as intrauterine infection, vesico-vaginal fistula or recto-vaginal fistula (or both).[31]

There are other medical conditions that are not necessarily resulting from pregnancy but leads to death when it occurs during pregnancy, at birth or immediately after delivery such as anaemia, malaria, hepatitis, cardiovascular diseases, respiratory diseases, Sickle Cell disease, meningitis, cerebrovascular and tuberculosis and others.[32] A number of complications and death can be averted, managed and reduced when proper medical care is administered.

Socio-Cultural Factor

These are influences resulting from the societal and cultural attitude and system of the people, the traditional beliefs and harmful practices that play negative roles in disallowing women access health services.[33] Such includes gender disparity in education, harmful traditional practices, ignorance, low literacy level, social distance (such as language barrier) etc. The community where women reside has great impact on her attitude to maternal issues.[34] The World Health Organisation stated that 'maternal mortality is an indicator of disparity and inequality between men and women and it portrays the extent to which women can access social, health and economic services and opportunities in the society'.[35] Other traditional harmful practices include circumcision of pregnant women and food taboos. A lot of times the eating habits of women are guided by the local taboos, administering of poisonous substances (regarded as traditional alternative medicine) before, during and after childbirth. Another important cause which is socio-cultural in nature is early marriage or child marriage, where young girls who are not biologically fit for pregnancy are pushed into marriage and childbearing. Averagely 27% of Nigerian women aged 15 to 19 are married and of these, 23% have begun childbearing, 9 % of women aged 25 to 49 have given birth by age 15, and 47% have become mothers by the age of 20.[36] The patriarchy nature of our society puts pressure on a woman to give birth to male children regardless of her health status; she is willing to endlessly go through pregnancy and birth until she is able to birth male children.[37] This male dominated societal structure exposes women to morbidity and mortality risk. Further, pregnant women are exposed to risk that could be averted with proper antenatal care, but prevented based on the cultural inhibitions that have been mounted by the society. The situation in the Northern part of Nigeria is even more critical because strong cultural beliefs and practice on childbirth

[28] Supra note 25.
[29] *Ibid.*
[30] *Ibid.*
[31] *Ibid*.
[32] *Ibid.*
[33] Aniekwu N. I. *Reproductive Health Law; A Jurisprudential Analysis of Gender Specific Human Rights for the African Region* (first Edition) Ambik Press Nigeria p. 85.
[34] Machando, C. J. & Hill, K. 'Maternal, Neonatal and Community Factors Influencing Neonatal Mortality in Brazil. (2004). *J. Blossoc. Sci.* 37: 193 – 208.
[35] World Health Organisation, UNICEF, UNFPA, and The World Bank ' Trends in Maternal Mortality : 1990 to 2008 (2010) , available online at http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf. (Accessed 25th July, 2020).
[36] National Population Commission (NPC) and ICF Macro, 2009 Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Population Commission.
[37] Aniekwu N. I. 'Examining the Reproductive Health and Rights of Nigerian Women: A Legal Perspective', *University of Benin Law Journal* Vol. 6 (2) 2001.

and fertility-related behaviours partly contributes significantly to the maternal morbidity and mortality picture compared to the Southern part of Nigeria.[38]

Economic and Infrastructural Factor

Poverty and lack of access to resources play a major influence in the high incidence of maternal mortality in Nigeria as a large number of Nigerians are impoverished. The World Population Data Sheet (2005) shows that 91 percent of Nigeria's lives below 2 dollars per day. Also in a USAID report (2006) it has been reported that about 60% of Nigerian lives in abject poverty and are incapable of paying medical bills, thus they are not seeking paid medical services.[39] The presence of poverty does not limit access to proper medical care alone, it also limits access to proper nutrition and consequently affects the immune system, creates anemia, increases infection rates amongst the poor and lowly, all these make them susceptible to diseases.[40] Poverty also debars women from engaging skilled attendant during childbirth, thus increasing the death rate.[41] Another area is the lack of adequate infrastructure in our health facilities and inadequate medical supplies, the inaccessibility of health facilities to women especially rural dwellers. Besides, the cost of medical care is beyond the reach of a lot of women who settle for cheaper ones that they find in the arms of local and traditional health attendants. Other infrastructures like means of transportation, bad road network that will aid getting women in the hinterland to a near health facility are lacking. All these are grouped together to constitute the economic and infrastructural factors that causes high incidence of maternal death in Nigeria.

Religious Factor

This factor could have easily come under the socio-cultural factor but this paper decides to separate it and give it a separate mention because of the strong role religion has come to play in the existence of an average Nigerian. A number of choices and decisions that women take are rooted in their various religious beliefs. People in the upper echelon of the society can boast that it has easily shaken off the influence of customary practice and cultural beliefs but are readily indoctrinated with religious beliefs that moderate their choices and decisions. In the case of *Medical and Dental Practitioners Disciplinary Tribunal* v *Dr. John Emewulu Nichola Okwonkwo.*[42] The patient (Mrs. Martha Okorie) was a Jehovah witness who refused blood transfusion together with her husband and had even put pen to paper to instruct that on no account should blood be transfused on her even if she goes into coma, as a result of this refusal, the patient died. This goes to show the extent that religious beliefs can influence the choices pregnant woman makes in Nigeria. Other harmful habits engaged in by women are equally based on religious beliefs.

Human Capital Factor

This factor has to do with the number, level and proficiency of people who attend to issues of pregnancy and childbirth in Nigeria. There are various forms of professionals in this regards; the orthodox and the traditional birth attendants. The orthodox consist of physicians, (gynaecologist), midwifes and nurses and other professionals in their team. The issue then is what is doctor/patient ratio in Nigeria? Is medical referral system operating effectively and efficiently? There are instances where traditional birth attendants are incapable of attending to a case based on its complexity, is there an effective referral pathway to a more competent professional? This is not limited to traditional birth attendants, there are equally levels of professionalism and speciality in medical practice, how and when will a general practitioner refer a patient to a more qualified medical professional for better care and attention. Ancillary to this is the menace of quackery in the medical field. There are a number of unqualified, untrained and fraudulent persons masquerading as healthcare giver and thus endangering the lives of

[38] Wall L.L. 'Dead Mothers and injured wives: the social context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria. *Stud Famm Plann* 1998; 29: 341-59.

[39] Husaini M. B. 'Causes of Maternal Mortality in Nigeria' http://www.academia.edu/3605112/Major_causes_of_Maternal_Mortality_in_Nigeria (accessed 10th July, 2020).

[40] Wermuth, L. *Global Inequality and Human Needs: Health and Illness In An Increasing Unequal World.* (2003). Person Education, Inc..

[41] Theddues, S. and Maine, D. ''Too far to walk: Maternal mortality in context''. *Prevention of Maternal Mortality Programme (PMMP)*, (1990). Columbia University.

[42] (2001) 6 NWLR (pt 710).

the patients that come to their health facilities; and of course there seems to be no ready and available means of verifying the genuineness of the practitioner and facility. Other challenge in this area is the incessant strike or industrial actions in our health institution.[43] Further is the issue of the ineffective means of addressing medical negligence by health care givers which makes them to be careless and carefree at times in their operations. Lastly there is the bickering and unhealthy rivalry that exists amongst and within the different strata of healthcare givers in Nigeria. There is always the bickering among doctors, pharmacists, Nurse, radiographers etc, about the issue of which designation of healthcare worker should head government health institution, who should the lead the medical teams.

Additionally, the quality and quantity of the healthcare professionals call for attention. How proficient are the skills of the healthcare practitioners being chunked out of our tertiary institution, how has the government invested in medical education and what provisions do we as a nation have for continuous medical education. This has led to brain drain wherein a lot of healthcare professionals happily find their way to other jurisdictions where they can express their knowledge, since they are provided with the tool of employment to practice. 'The emigration of African professionals to the West is one of the greatest obstacles to African's development'.[44] Ethiopia is leading in terms of brain drain, followed by Nigeria then Ghana.[45] The sad reality then is that Nigeria is educating her populace for the consumption and use of other nations in the globe. Nigeria has not been able to meet its doctor-patient ratio, yet the she keeps losing health professionals to other nations. Nations like Cuba and India have their doctors trained in industrialised western nations only for them to return and contribute to the health development of their nations. Some of the factors attracting medical doctor to other nations include substantial funding for medical research, advanced technology, modern facilities and experienced support staff while factors that drive away the medical professionals are under-utilisations of specialists and qualified professionals, poor working conditions and environments, lack of research facilities etc.

Political Factors

This has to do with the government's commitment to women's health and right. What are the existing health policies in place that protects women's health? Matters of health fall under the concurrent list of the Constitution, the implication being that both the National and state Houses of Assembles have the authority to legislate on matters of health.[46] Equally the three tiers of government in Nigeria are involved in health care delivery; the primary health care system is handled by the local government, while the secondary health care is handled by various states and the Federal Government has the responsibility to provide the tertiary health care. 'The Federal Government is largely responsible for policy guidance planning and technical assistance, coordination of state level implementation of the National Health Policy and the establishment of health management information system'.[47] The primary health care is designed to reach the rural dwellers and grass root and to serve as the first contact or first point of call for majority of the sick including pregnant women, however, evidently, the primary health care system has not been able to deliver adequate service to the populace in this regard.[48] Over the years the Federal Government has adopted several health policies, but the health policies may not be functional in a nation like Nigeria with no sustainable health insurance scheme or social security system. This has an undulate effect on the care of women, especially women during pregnancy and birth.[49] Though the National Health Policy was signed into law, but there is lots of skepticism on its workability because some of the bases of its operations are not in place. The role that a good and effective government policy plays cannot be under-emphasized in improving or aggravating issues of health in Nigeria. Effective and sustainable policy encourages private investments in health, health services and aids to health both from the international and local investors. The lack of effective government policies and commitment to other

[43] at the date of this research, there is the presence of COVID 19 pandemic and there are threats of Resident Doctors going on strike.
[44] United Nations Economic Commission for Africa (ECA).
[45]'Brain Drain in Africa : Facts and Figures' http://www.aracorporation.org/files/factsandfigures.pdf (Accessed 26th May, 2020).
[46] Supra note 33, p. 87
[47] *Ibid.*
[48] Supra note 39.

ancillary issues to health such as environment, good water supply, pests control etc. play a major role in the high incidence of maternal death. Basic measures such as mosquito and pest control are of immeasurable benefit to reduction of maternal death.[50] It is medically acclaimed that pregnant women and children are vulnerable to malaria and its complications.

The depth of corruption in the government is also a big blow to maternal health, coupled with many years of poor governance, military rule. Over time, power has been concentrated in the hands of a few elites and as such health infrastructure has been eroded and corruption has increased.[51] There have been accusations and counter accusations in government circle about funds budgeted and aimed at improving health facilities but have been diverted for personal use. Other issues under the political factor are bureaucracy and administrative bottleneck. How urgently are the health facilities treating emergencies without the usual administrative protocol which is often directed at protecting themselves from government sanctions? Added to this is the common fact in Nigeria that Nigerian leaders do not seek and obtain medical care in Nigeria, they travel to developed nations to get proper healthcare. This has created the *laissez- faire* attitude to the local health service delivery. The bottom-line is that the political factor serves as the underlining denominator of the other factors; because where there is the political will to solve the problem, other factors will find their resolves.

4. Getting it Right

Over the years there have been a lot of international and national initiatives commitment and collaboration aimed at reducing maternal mortality. The world came together under the MDGs and listed the lowering of maternal mortality as its number 5 attainable targets by 2015.[52] The United Nations reported that from 1990 to 2010, there has been a decline in the global maternal death from about 543,000 to 287,000; this is about 47 percent reduction.[53] The yearly rate of decline of the global MMR since 1990 was 1·3% (1·0—1·5).[54] However, the Nigerian scenario is far from recording this feat, as shown by available data both locally and internationally. The previous approaches engaged in solving this challenge, at times is caught up in the web of other causative factors as well. For instances, when palliatives such as funding for 'seemingly sufficient medical materials' are included in the budget, one of the political factors such as corruption would swallow up this palliative and the vicious circle keeps going. Heads of African Unions met in 2001 in Abuja with the aim of creating a plan of improving the health sector of their countries, they hence formed the Abuja Declaration wherein Article 26 of it describes the goal of the policy that:

> we commit ourselves to take all necessary measures to ensure that the needed resources are made available to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilised… we pledge to set a target of allocating at least 15 (percent) of our annual budget to the improvement of the healthcare sector.

This statement appears to capture the effective approach towards reducing maternal mortality. 'All necessary measures' need to be taken as well as 'the needed resources' be made available from 'all resources. Thus financial, social, religious and political (etc.) resource should be employed at tackling this challenge. Giving lone solution or single sided solutions will never help at reducing this menace because the problem is caused or aggravated by so many factors as discussed above. Therefore, achieving any form of result entails a comprehensive, joint and holistic approach by the government who are to lead the governed in achieving a reduction of maternal death. Therefore, comprehensive

[50] Supra note 40.
[51] Supra note 39.
[52] Rosemarin A.,Ekane N., Caldwel I., Kvarnstrom E., McConville J., Ruben C., Fodge M. *Pathways for Sustainable Sanitation: Achieving the Millennium Development Goals* IWA Publishing (2008). See also, Holmner-Marlene M. 'The road to the information and knowledge society : indigenous knowledge and the Millennium Development Goals' (2011) Mousaion Vol. 29 Issue 2 pp. 139-157
[53] Global Health Programs Report to Congress FY 2012, http://www.usaid.gov/sites/default/files/documents/1864/CSH-finalwebready.pdf (Accessed 25th August, 2120).
[54] Policy Brief On MDG's 4 & 5: On Reduction Of Under Five And Maternal Mortality Rate Policy Brief On MDG's 4 & 5:On Reduction Of Under Five And Maternal Mortality Rate http://www.cislacnigeria.net/wp-content/uploads/2012/05/Reduce-Under-five-and-Maternal-Mortality.pdf

plans and effort are to be made in order to achieve any meaningful reduction in maternal death in Nigeria. WHO advocates certain key working areas such as:

- Strengthening health systems and promoting interventions focusing on policies and strategies that work, ensuring they are pro-poor and cost-effective.
- Monitoring and evaluating the burden of maternal and new-born ill-health and its impact on societies and their socio-economic development.
- Building effective partnerships in order to make best use of scarce resources and minimize duplication in efforts to improve maternal and new-born health.
- Advocating for investment in maternal and new-born health by highlighting the social and economic benefits and by emphasizing maternal mortality as human rights and equity issue.
- Coordinating research, with wide-scale application, that focuses on improving maternal health in pregnancy, during and after childbirth.

Though this paper agrees in principle with these working options, however, the options may be too general and inexplicit especially to nations like Nigeria where the necessary process is not available to interpret and execute these key focuses; Therefore, specific and practical options are deemed more suitable, though each of these specific solutions should be combined and engaged together. Until there is a combined and joint engagement of all available plans and efforts, there may be no substantial reduction in maternal death in Nigeria. This is because there is an interconnectivity of all the causative factors, hence if all is not combated jointly, each cannot be fought alone. Below therefore this paper discusses in a practical and holistic manner what can be done to every causative factor identified so as to reduce to this danger ravaging our nation.

S/N	FACTOR	REDUCTIVE MEASURES
1.	**Medical Factor**	A lot of the medical causes identified in this area are both preventable and treatable. Therefore, since all these causes have been identified, there should be capacity building of medical professionals in tackling it. Adequate medical facilities, like drugs etc. should be provided in sufficient quantity. Further, accessible and affordable health care system should be made available because the affordability of the health facilities creates better patronage from the public. Healthcare giver should be trained and encouraged to develop more inviting and accommodating attitude so as to make local women (especially) to more comfortable with the orthodox health facilities. Women from the grassroots often prefer the traditional birth attendants because of the unfriendly and harsh attitude of the personnel in the orthodox facilities. Generally the health system should be strengthened through policies, attitude and cost-effective treatment. The issue of medical bureaucracy should equally be removed or reduced so as to encourage ante-natal culture among pregnant women. Similarly, medical administrative procedures should be easy, friendly and noncomplex. Thus, the training schools should inculcate into the would-be healthcare givers 'customer-centric' attitude, aimed at focused and seamless service delivery.[55]
2.	**Socio-Cultural Factor**	Since culture is dynamic, then the dynamism of culture can be used to achieve mortality reduction through education, enlightenment, encouragement and enforcement. There have been a lot of advocate on radio education and jingle, this paper equally subscribes to such, but far beyond the radio messages alone, the government should take positive steps by introducing into the education curriculum Gender Studies. It is recommended that an entirely new subject termed

[55] See Adebowale S.S. supra note 17.

		'Gender Studies' be introduced into the education curriculum of Nigeria from the kindergarten to the tertiary level. This new subject should run *pari pasu* with other conventional subjects like English language. physics, chemistry, mathematics etc. when this is done, the young minds are taught early on how to take care of their bodies and lives. The young girls know the importance of adequate care and their young mind is disabused from cultural inhibition. The boys too are not left out they are taught the value of support system in the family and the obligation of procuring adequate health care for pregnant ladies. Pupils and students should be able to relate curriculum to personal life and living. The enlightenment campaign should be 'target' focused. It should take into cognizance the mental ability and language appreciation of the targeted audience; thus actual communication should be achieved. Campaign languages should be clear and familiar to the public where possible, in some local languages where the people can connect and not some 'westernised' language which is unfamiliar to the audience. Further, there should be a form of enforcement or sanctions to old and unyielding traditionalist who continues the ancient practice that increases the maternal and infant death. The fear and certainty of sanctions has a way of reducing any malpractice. While encouragement should be given to mothers in terms of material support such as immediate material reliefs like free packs of diapers, toiletries, food supply etc. for short periods after birth. This will encourage would-be mothers to patronise accredited health facilities. Also, traditional birth attendance scheme should be strengthen, training, retraining and re-orientation of these birth attendances should be embarked upon, and a reward system should be worked upon so that these sets of people will be willing to come out for collaboration with the government. Structures which the Government can also leverage are the traditional royal institutions that exist in Nigeria. There is a well-structured traditional headship in Nigeria which the colonialist saw and made use of. This structure too can be positioned to meet this challenge since most of the traditional rulers are closer to the members of their tribe.
3.	**Economic and infrastructural factor**	Adequate budgeting for health is imperative if any government is serious in achieving reduction in maternal death. Maternal health should take priority in economic planning of the nation. Antenatal care, delivery, including operative delivery should be free and accessible to all. This free maternal healthcare should be for the period composing of a generation; 25 years duration should be the target for free and accessible maternal health care. After the expiration of 25 years, payment for service delivery should be gradually introduced since the incoming generation would have acquired the basic enlightenment through Gender Studies. The present health delivery structure should be strengthened and emphasis should be given to rural dwellers by erecting more medical facilities among the rural dwellers and the urban poor. These can be achieved through adequate budgeting and economic planning. In fact the medical factor can only be addressed through adequate planning, financing and funding. Hence, this reductive measure seems to form the foundation of the other measures.
4..	**Religious Factors**	Collaborations with the leading religious leaders in the country. Over the years, there have been a lot of mistrust in the government but continually people repose high hopes, faith and believe in their religious leaders whom they have found solace in times of trouble.

		Thus, the government should collaborate and partner with the religious leaders in educating their faithfuls on this issue. Religious leaders should equally be won to the side of safe maternal health. Going sideways with this is the education of religious bodies especially the one that provide birth facilities to its members to recognise their limits and when to refer to health facilities for complicated cases. The Government should also subtly create a sanction system for religious bodies that goes beyond the allowed medical scope as regards maternal health.
5.	**Human Capital Development**	Healthy human capital development certainly affects a countries economic and socio-cultural development and increases productivity.[56] Health service unfortunately is a team-based delivery services, wherein a lot of hands are needed both specialised and unspecialised. Often, focus is placed on the specialised hands at the detriment of the unspecialised hands; whereas, a lot of hazards are done by the untrained unspecialised hands. Thus this paper is recommending the registration, training and strengthening of these unspecialised hands such as Wards Attendants, Auxiliary Nurses etc. This type of work should be regulated because unlike other menial jobs that people engage in, they are dealing with human lives. Additional, both the government and the professional bodies should confront the menace of quackery; both the orthodox and unorthodox quackery. The government too should invest more in medical training, both the medical schools education and continuous medical training so as to build capacity of the medical practitioners. Points systems should be embraced and extended to all medical professionals, (not just doctors) wherein points are awarded for each continuous medical education a practitioner attends in a year and failure to meet up with the number of points may attract sanctions. Similarly, on this, both the government and professional unions should be sincere, open and credible to their agreements so as to avoid incessant trade disputes. Finally, when patients become victims of medical negligence, simple and accessible redress/compensational system should made so as to boost public trust.
6.	**POLITICAL FACTORS**	As mentioned earlier in the paper, the political cause is perhaps the underlining denominator of other factors because the political will to solve the problem is the driving tool to achieving success. Therefore the government must develop the will and drive at reducing maternal death to the barest minimum. The government should not just publicise and make 'fun-fare' of intangible efforts, rather serious and determined effort should be exercised at resolving the challenges. Towards this, issue of corruption must be addressed. With the high presence of corruption in our nation's life, little can be achieved in this regard. All workable political tools should be employed at lowering corruption in Nigeria. Further, the Government needs to create a sustainable, workable and effective maternal health care policy with the focus of immediate, short and long term needs. This should be made in a manner that it can be sustainable and outlive the regime of a particular government and political party. Thus structures should be built to sustain the policy rather than individuals. A number of previous efforts are built around

[56] Savvides A., Stengos T., *Human Capital and Economic Growth* (2008) Stanford University Press.

		individuals. For instance wives of serving Governors make this type of challenges that is, maternal mortality their 'pet projects', and after their husbands leave power and office, such programmes collapse. Those structures should be built so that their operation is devoid of individualism but institutions. Ondo State appeared to have had a lead in reducing Maternal health in Nigeria presently through its *Abiye* programme. The international community acclaimed the programme as successful and a model for other African Countries to emulate so as to achieve the MDGs goal 4 and 5. In fact as of June 12, 2011 barely 15 months into the operation of this programme, 2526 patients had been treated and about 5,879 babies safely delivered out of which 905 were by caesarean section. When this is compared with major medical facilities in four different states it indicates that the *Abiye* Programme had the lowest maternal mortality ratio during its first year of operation.[57] Fantastic as this programme is, the problem with the Nigeria political climate is that this may go with the political dispensation of Governor Olusegun Mimiko the 'visionier' and originator of the scheme. Programmes and ideas in Nigeria are often not anchored on structures, thus they are short lived.

5. Conclusion

Maternal mortality or death is the death of a woman during pregnancy or labour as a consequent of pregnancy within forty-two days after delivery or abortion. The only known process by which human beings increases and multiplies is through pregnancy and delivery. It is therefore incumbent on us all to make this process safe and peaceable as possible. The world has taken this challenge very seriously and a lot of human, financial, material and physical resources have been committed at reducing and eradicating death of mothers during and immediately after pregnancy. The successes recorded at the world level are unfortunately not exhibiting in Nigeria. Nigeria accounts for the second highest maternal mortality in the world after India. This is alarming and should not be left as it is, therefore, comprehensive and combined efforts should be put in addressing the situation. The cause of the high index recorded in Nigeria is classified into six factors which are - medical, socio-cultural, economic and infrastructural, human capital, religious and political factors. There have been previous efforts by the Nigerian government at reducing this challenge, but there has been little success recorded. But the bottom line is that based on the six causative factors identified in this paper, there is the need for a combined and comprehensive regulatory and policy backup for all these measures aimed at reducing maternal death in Nigeria. The combined intervention should be anchored on a structure and not on individual. Anchoring it on a structure requires a strong regulation and policy for sustainability and continuity. Finally, safe motherhood is human right; right to life and survival. A woman must be protected from dying as a result of pregnancy and child birth.[58]

[57] 'World Bank seeks adoption of Ondo State's Abiye project as model for Africa'. *Vanguard Newspaper* July 19, 2011. See also Fajimbola T. 'Abiye Safe motherhood: A case of Leadership in turning the tide of Maternal Mortality in Nigeria' (2011) *nigerianhealthjournal.*

[58] Aniekwu N.I., Uzodike Eunice U., Legislating Gender, (Re) producing Rights: A Analysis of African Case Law, Vol. 30, No. 2 *Journal of Social Welfare & Family Law*, University of Liverpool, U.K. (2008).