

Provision of essential obstetric care (EOC): a sine qua non to reducing maternal mortality rate in Nigeria

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Abstract: Nigeria's maternal mortality rate has been on the increase even after the launching of the Safe Motherhood Initiative (SMI) 16 years ago. The causes of this increase are well known, and mainly result from inability of a health system to deal effectively with complications, especially during or shortly after childbirth. Shortage of health professionals and health facilities equipped to offer EOC and emergency obstetric care 24 hours a day are significantly related to quality of care and maternal mortality rates. Since the Primary Health Care (PHC) level is usually the first contact point for the majority of our women, it must be able to deliver the essential services in full and make appropriate referrals when necessary. From available statistics, provision of EOC services in Nigeria has been deplorable. Deficient areas within the health system concerning EOC services are highlighted and suggestions made on how to improve and sustain services.

It is concluded that provision of effective and efficient EOC facilities and services will play a key role in maternal mortality reduction, not only in Nigeria but in most developing regions of the world. (Promot Educ, 2008; 15 (4): pp. 50-52)

Key words: essential obstetric care (EOC), improved services, maternal mortality reduction

Nigeria's maternal mortality rate has been rising despite the launching of the Safe Motherhood Initiative (SMI) 16 years ago. Available data indicate that Nigeria has one of the highest rates of maternal deaths in the world. Officially, the maternal mortality rate is estimated at 800 maternal deaths per 100,000 live births (1). However, based on the recent report by the Society of Gynaecology and Obstetrics of Nigeria (SOGON), the picture is rather frightening and staggering. According to that report, the maternal mortality rate ranged from 3380 in Lagos, southwest Nigeria to 7523 in Kano, Northern Nigeria (2). Whereas Nigeria makes up 2% of the world's population, it contributes about 10% of the global burden of maternal deaths (3). It has been estimated that 1:18 mothers in Nigeria faces a lifetime risk of dying from pregnancy-related causes compared to 1:2400 in Europe (4). Many that survive are faced with short- and long-term disabilities.

Available statistics indicate that the leading causes of maternal deaths in Nigeria include obstructed labour, postpartum haemorrhage, eclampsia and pre-eclampsia, puerperal sepsis, ruptured uterus and unsafe abortion (5-10).

These causes are well known and mainly result from the inability of a health system to deal effectively with complications especially during or shortly after child birth (11). It is evident also that several proximate and intermediate social and economic factors make substantial contributions to these maternal deaths. The pervading high level of poverty in the country especially among women, the low status of women, high prevalence of harmful traditional practices, all add up to pose great obstacles to women's access to much-needed reproductive health information and services.

To date, very few interventions have specifically addressed the reduction of maternal mortality in Nigeria. It has been shown that the availability and quality of essential obstetric care (EOC) facilities is regarded as a measure of progress towards maternal mortality reduction (12). Shortage of health professionals and health facilities equipped to offer EOC and emergency obstetric care 24 hours a day are significantly related to quality of care and maternal mortality rates (13). Currently, health systems are functioning poorly, with weak referral systems, especially during obstetric and

neonatal emergencies. The primary health care (PHC) level is usually the first level of contact between women and the health care system (private and public). At this level, it is important that skilled care is provided. PHC must be able to deliver the essential services in full, which include: focused antenatal care and family planning, prevention of mother-to-child transmission of HIV and early disease detection and treatment, normal delivery including use of partograph and active management of third stage of labour, care of mother and newborn in the postnatal period (warmth, cleanliness, resuscitation and prevention and management of sepsis), early initiation of exclusive breastfeeding and early detection and timely referral with minimal first-line management of women with pregnancy-related complications. At the PHC level, the facilities should be equipped to offer basic essential obstetric care (BEOC) and should have at least four to five midwives with life-saving skills and equipped to offer parenteral antibiotics, sedatives, oxytocics and manual removal of placenta and products of conception 24 hours daily. Some pregnant women will require access to specialized medical services for diagno-

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sis and treatment of an underlying health problem or pregnancy-related complications. These women must be referred to a secondary-level health facility that offers comprehensive essential obstetric care (CEOC) with the necessary drugs, equipment and skilled staff to manage such complications. Services provided at this level include: surgical procedures including caesarean section, blood banking services, safe blood transfusion and assisted delivery.

In a recently concluded national study on EOC facilities in Nigeria, the proportion of facilities that met the EOC criteria was 4.2% for public facilities and 32.8% for private facilities; overall, only 18.5% met the EOC criteria (12). The same study revealed that the distribution of EOC facilities in each of the states was very uneven, with most of them located in the urban areas while the rural areas, where most of the population lives, are highly underserved. In all, the proportion of deliveries that took place in facilities meeting EOC criteria was just 5.9% (12). The National Demographic and Health Survey (2003) (14) reported that only 61% of pregnant women receive antenatal care at least once from a trained provider and only a third (32.6%) delivered in health facilities while the proportion of pregnant women that had skilled attendants at delivery was 35.2% and 16.9% delivered on their own with no assistance from anyone.

Therefore, provision of efficient and effective EOC services should be emphasized and should be seen as the tripod on which the real reduction of maternal mortality should stand. There are several issues that require urgent attention in this regard, for instance the weak human resource development and management, including the continuing brain drain of skilled personnel within and outside Africa and from public to private sector; poorly functioning health systems, with weak referral linkages; inadequate financial support; poor logistics for management of drugs and family planning commodities; and lack of necessary infrastructure and equipment for effective service delivery.

Health systems should be strengthened with both human and material resources to make them functioning and functional. Indeed the availability of skilled health providers (particularly midwives, nurses, doctors and obstetricians) is critical in assuring high-quality antenatal, delivery and emergency obstetric and postnatal services. In fact, the Millennium Development Goal for maternal health (MDG-5) is unlikely to

be achieved without attention to the recruitment and retention of health professionals (15). Their services should be made more accessible, available, acceptable, affordable and user friendly, and should be equitably distributed in both rural and urban centres. Incentives should be given to skilled personnel to attract them to rural areas where their services are most needed.

Weak referral systems, especially during obstetric emergencies, contribute significantly to delays in reaching health facilities for prompt and appropriate care. There must be an effective and efficient referral system linking all levels and in some cases between higher levels of care within the same facility where these exist. Such a system must include feedback to the original referral point or health professional in order to foster an ethos of reflective practice and for strengthening continuity and quality of care. Procurement and installation of appropriate communication equipment including mobile phones, two-way radios and emergency means of transportation including ambulance services will aid prompt referral. Also, fostering community participation in strengthening the referral system is essential for bridging the gap between facility and community.

Side by side with the provision of efficient and effective EOC services is the creation of enabling environment for the populace to avail themselves of the services. For instance, there is a need to improve the poor infrastructural facilities such as rural road network and transportation as well as safe water and sanitation problems. Pervading poverty, particularly among women, impact seriously on affordability of services. Therefore, there is a great need to improve the socio-economic status of our women. Negative socio-cultural barriers and harmful traditional practices that are inimical to the tenets of healthy living and safe motherhood should be abrogated through advocacy and legislation. Government should review hospital fees and charges to make services more affordable as this scares our women away from availing themselves of appropriate care.

Furthermore, the household and the community have an important role to play in improving maternal health and reducing maternal mortality. Using approaches and mechanisms, such as Behaviour Change Communication (BCC), communities can be empowered to define, demand and access quality skilled care through mobilization of

community resources. Active participation of the community enhances self-reliance, ownership and sustainability of key actions. Women should be aware or made to know the important key elements of self-care in the home for pregnant women, such as proper diet and nutrition, good personal hygiene and healthy lifestyle, timely decision making related to care seeking during pregnancy, childbirth and the postnatal period. This includes seeking antenatal care so that conditions detrimental to health can be identified and treated or treatment commenced and an appropriate plan for birth and care after can be developed.

In conclusion, there is an urgent need for a concerted effort on the part of individuals, communities, governments and partners interested in improving women's health towards putting in place workable structures at our health care facilities to curb maternal deaths. Governments should make maternal death a compulsorily notifiable event in Nigeria and enforce reviews of such events to correct and improve the health system and not necessarily as a punitive measure. They should facilitate the empowerment of women for financial independence to enable them to make their own decisions on health matters based on appropriate information and knowledge of available services. They should also develop the capacity of community groups including faith-based associations and their leaders to appreciate their roles as generators of health and to assume their roles as partners in improving maternal health. Finally, in order to achieve the Millennium Development Goal target of reducing the maternal mortality rate by three-quarters and ensuring that 60% of all births are assisted by skilled health personnel by 2015, it is suggested that government should upgrade the skill of the health workers in EOC, strengthen the operational capacity of health facilities for quality EOC service provision and continuously monitor EOC achievements.

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