



Why Are Women Dying While Giving Birth In Nigeria?



Supported by funding from:



Why Are Women Dying While Giving Birth in Nigeria?

A Community-informed Maternal Death Review

Copyright ©2020 Africare, Nigeria Health Watch and EpiAFRIC

This report is produced by Africare, Nigeria Health Watch and EpiAFRIC.

This report is supported by funding from MSD, through MSD for Mothers, the company's \$500 million initiative to help create a world where no woman dies giving life. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, NJ, U.S.A.

All rights reserved.

Published November, 2020

Cover Design, Layout and Infographics by S. Lamai

Why Are Women Dying While Giving Birth in Nigeria?

**A Community-Informed Maternal
Death Review**

“Sometimes I don’t know if I will die when I give birth to the child. I am mostly worried about the day of birth. I feel worried every day, even now.”

- pregnant woman in Izzi, Ebonyi State

Contents

**THE GIVING
BIRTH IN NIGERIA
PROGRAMME**

6

**EXECUTIVE
SUMMARY**

7

**MATERNAL
DEATH REVIEW
OF WOMEN IN
COMMUNITIES**

11

**WHY ARE WOMEN
DYING WHILE GIVING
BIRTH IN NIGERIA?**

13

**MENTAL HEALTH
AND MATERNAL
HEALTH CARE IN
NIGERIA**

39

**GIVING BIRTH IN
NIGERIA DURING
THE COVID-19
PANDEMIC**

41

**CHARTING A
FUTURE WHERE
MOTHERS LIVES
MATTER**

44

REFERENCES

51

THE GIVING BIRTH IN NIGERIA PROGRAMME



In January 2019, a consortium consisting of Africare, Nigeria Health Watch and EpiAFRIC was established to implement an 18-month community-informed maternal death review programme. The Giving Birth in Nigeria programme was conceptualised to provide an inquiry into the reasons pregnant women were dying in communities and to pilot a community accountability mechanism for maternal deaths. According to the 2018 Nigeria Demographic and Health Survey, 61% of live births do not take place in a health facility. The programme aims to establish a foundation to catalyse greater accountability for previously undocumented community maternal deaths in Nigeria.

This programme is supported by funding from MSD, through MSD for Mothers, the company's \$500 million initiative to help create a world where no woman dies giving life. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, NJ, U.S.

The Giving Birth in Nigeria programme was formed to find out why women are dying while giving birth in communities, thereby creating a sense of urgency and using the data and insights from the review to create collective responsibility for the death of every woman. The programme calls for a bottom-up approach, starting from action in the community, pushing for greater collaboration among stakeholders across all levels of decision making and eventual sustainability in building actionable solutions and lasting change.

During the programme, Africare led community mobilization efforts, with Nigeria Health Watch leading on advocacy and multi-stakeholder relations and EpiAFRIC leading on research, data analysis and monitoring.

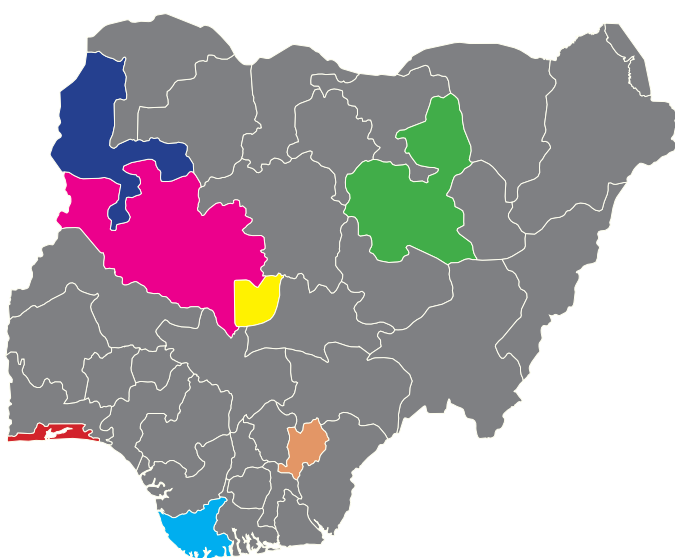
A baseline survey was carried out in April, 2019. The community review was carried out from May 2019 to May 2020. In the period of review, 133 maternal deaths were documented in 18 communities in the six focus states representing all the six geopolitical zones. Out of these maternal deaths, 52 deaths took place at home, 28 deaths occurred in the home of a Traditional Birth Attendant (TBA), 18 deaths occurred in a faith-based institution, and 17 deaths were in a health facility. Before the Giving Birth in Nigeria programme, these communities had never been reviewed for maternal deaths.

EXECUTIVE SUMMARY



The purpose of this “Why Are Women Dying While Giving Birth in Nigeria?” report is to raise awareness of the high maternal mortality burden in Nigeria, particularly the high prevalence of maternal deaths in communities, where there has been no previous systematic attempt to ensure that deaths that did not occur in a health facility were incorporated into any routine review or Maternal and Perinatal Death Review and Response (MPDSR). The aim of this report, through data collection efforts, is to drive multi-stakeholder awareness, accountability and action for maternal deaths in Nigeria, particularly in communities. The goal is to inform advocacy for the establishment of systems at all levels of government from national, state to local that will ensure accountability for maternal deaths and collaboration for solutions. While the outcomes are adverse, every maternal death, wherever it occurs, must be counted and investigated, and lessons learnt to drive improvements in maternal health care.

The review was carried out in six states representing each geopolitical zone in Nigeria: Bauchi, Bayelsa, Ebonyi, Kebbi, Lagos, and Niger States and the FCT. These states acted as windows to the rest of their respective geo-political zones, representing the diverse cultures, attitudes and beliefs of each region. The review took place from May 2019 to May 2020 and uncovered insights into maternal health outcomes in communities in Nigeria. There were no maternal deaths recorded in the programme communities in FCT, hence the absence of FCT in the analysis.



Six states representing six geopolitical zones in Nigeria:
Bauchi - North-East, **Bayelsa** - South-South,
Ebonyi - South-East, **Kebbi** - North-West,
Lagos - South-West and **Niger** - North-Central and the **FCT**.

STATE HIGHLIGHTS

Bauchi State

In the Bauchi State baseline survey, 17 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions. The results of the Bauchi State baseline survey are fully dependent on the response from these women.

In Bauchi State, according to results of the community-informed maternal death review, 75% of maternal deaths occurred in health facilities, while 25% of maternal deaths occurred at home. The largest contributor to maternal deaths was postpartum haemorrhage, contributing to 50% of maternal deaths recorded in the review. Prolonged obstructed labour was responsible for 33% of maternal deaths recorded.

Key Insight

Local culture significantly influences the health-seeking behaviour of younger women who rely on the decision-making role of older women like mothers and mothers-in-law. They are the most influential people in the lives of younger women, acting as gatekeepers and should be engaged in the drive to foster better maternal health-seeking behaviour. Efforts to capture community maternal deaths and maternal health-seeking behaviours must incorporate the involvement of these highly revered community influencers. These community influencers can help to lead the drive towards an increased uptake of facility-based maternal health care.

Bayelsa State

In the Bayelsa State baseline survey, 15 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions. The results of the Bayelsa State baseline surveys are fully dependent on the response from these women.

In Bayelsa State, according to results of the community-informed maternal death review, 50% of maternal deaths occurred in the home of a traditional birth attendant, otherwise known as “*Massager*”, with 33% of maternal deaths occurring at a health facility and 17% of maternal

deaths occurring at home. Postpartum haemorrhage was responsible for the majority of maternal deaths recorded, at 50%, while prolonged obstructed labour was responsible for 33% of maternal deaths and convulsion for 17% of all recorded maternal deaths.

Key Insight

There is a high level of trust between Traditional Birth Attendants (TBAs), widely known as “*Massagers*”. This is due in part to the poor interaction of women in local communities with the formal health system, owing to poor accessibility, communication challenges between health care workers and members of the community and the poor attitude of health care workers. TBAs are particularly popular given their familiarity with women in the community and their residence in the community. Flexible payment terms offered by the TBAs, and their willingness to offer abortion services are other attractive motivations that encourage continued patronage of the “*Massagers*”.

Ebonyi State

In the Ebonyi State baseline survey, 18 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions. The results of the Ebonyi State baseline surveys are fully dependent on the response from these women.

In Ebonyi State, according to results of the community-informed maternal death review, postpartum haemorrhage contributed to 36% of recorded maternal deaths closely followed by prolonged obstructive labour, which was responsible for 32% of all maternal deaths recorded. Also, convulsions contributed to 13% of all maternal deaths in Ebonyi State followed by infections from fever at 4% and complications from abortions at 2%.

Key Insight

Cultural beliefs are impeding women’s ability to seek facility-based births. One widespread cultural belief by women in Ebonyi is that women who have caesarean sections are weaklings. The women believe that they must deliver as the “Hebrew Woman”, revered in the pages of the Bible’s Old Testament. Women must therefore be supported in their demands for access to health care facilities so that trained midwives can give them proper care. Statistics alone are not driving home the message and leading to behaviour change. Health facilities exist; however, health education and community sensitization are crucial to ensuring that women and their families are empowered to alter their health-seeking behaviours to enable them to give birth in better conditions and prevent maternal death.

Kebbi State

In the Kebbi State baseline survey, 21 women were randomly selected from a pool of pregnant women attending

antenatal care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions and key informant interviews with programme officers and data collectors. The results of the Kebbi State baseline surveys are fully dependent on the response from these women.

In Kebbi State, according to results of the community-informed maternal death review, the highest contributor to the maternal deaths recorded was infection with fever, contributing to half of the recorded maternal deaths. Prolonged obstructed labour contributed to 38% of all maternal deaths in the state, while postpartum haemorrhage contributed to 13% of maternal deaths recorded in the state.

Key Insight

The cultural influence of the man as the key decision maker and the aversion for male health care workers exert a strong influence on the health-seeking behaviour of women in communities and this ultimately affects maternal health outcomes in these local communities. Women may have to seek and obtain permission from their husbands before they can access facility-based health care.

Lagos State

In the Lagos State baseline survey, 16 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions. The results of the Lagos State baseline surveys are fully dependent on the response from these women.

In Lagos State, according to results of the community-informed maternal death review, the two major causes of maternal deaths were, postpartum haemorrhage and prolonged obstructed labour both contributed 26% each of all maternal deaths recorded in Lagos State. This was followed by convulsion accounting for 23% of maternal deaths in the state. Complications arising from abortion procedures contributed to 6% of deaths, ruptured ectopic pregnancy contributed to 5%, and infection from fever contributed to 2% of maternal deaths in Lagos State.

Key Insight

There is a significant reliance on faith-based maternal health care over facility-based maternal health care in Lagos State. This has been attributed in part, by some of the women, to the unpleasant treatment being faced with health care workers, particularly nurses, and increasingly, doctors. A reliance on religious beliefs contributes to health-seeking behaviours that place faith-based centres before health facilities when it comes to seeking maternal health care.

Niger State

In the Niger State baseline survey, 20 women were randomly selected from a pool of pregnant women attending antenatal

care (ANC) classes and nursing women attending postnatal care (PNC) classes). These women were engaged in focus group discussions. The results of the Niger State baseline surveys are fully dependent on the response from these women.

In Niger State, according to results of the community-informed maternal death review, prolonged obstructed labour contributed to 67% of all maternal deaths recorded in the state, with postpartum haemorrhage contributing to 33% of the maternal deaths. All maternal deaths that were recorded in Niger State occurred at home.

Key Insight

Cultural influences dictate that husbands make health care decisions on behalf of their wives. In their absence, women are not empowered to act. A woman may not access facility-based maternal health care until she seeks and obtains permission from her husband.

Mental Health and Maternal Health Care in Nigeria: Key Highlights

- During pregnancy, women are faced with high levels of anxiety and no support mechanisms. Anxiety is focused mostly on expectations of labour and giving birth and further aggravated by reports of maternal deaths in their communities
- Women lack information on causes of maternal deaths and how it can be prevented
- Religion is a common coping mechanism for most women. Women resort to their faith as a way to mitigate their fears and worries
- Women lack emotional and practical support from their partners and their mental health and emotional needs are not addressed in antenatal care (ANC) or postnatal care (PNC) where available.

Giving Birth in Nigeria During the COVID-19 Pandemic: Key Highlights

- During the COVID-19 pandemic, there is difficulty in accessing health facilities for antenatal care (ANC) and other routine pregnancy screenings due to scaled-down operations which has led to reduction in antenatal care (ANC) and postnatal care (PNC) attendance
- During the COVID-19 pandemic, women face financial pressures from the lack of daily earnings resulting in pressure on family budgets and reduced access to and consumption of nutritious foods
- During the COVID-19 pandemic, women experience increased anxiety from fear of contracting coronavirus during labour and other attendant consequences of the COVID-19 pandemic.

KEY FINDINGS AND RECOMMENDATIONS

Primary Recommendation

- **Underscoring the Role of Community**

Leadership and Collaboration in Facilitating Community Maternal and Perinatal Death Surveillance and Response (MPDSR)

Traditional and religious leaders are the most influential people in communities as they function as cultural gatekeepers and guides to women and their families. They are fully engaged in resolving non-compliance with safer and better health care practices and must be involved in the drive to foster better maternal health-seeking behaviours. State governments must commit to building upon these existing socio-cultural structures to accelerate accountability for maternal deaths at the community level, through community leadership, and to advocate for the adoption of safe practices in maternal health care. Following the findings of this review, the federal government through the Federal Ministry of Health should work with state governments, local governments and ward development committees to facilitate community MPDSR. This should be implemented as a multi-stakeholder effort that will involve the initiative of community influencers, community-based organisations (CBOs), religious leaders and health workers including community health extension workers (CHEWs). This community-informed review of maternal deaths has provided a framework for monitoring maternal deaths at the community level. The charge to the federal government, state governments and local governments should be to put in place sustainable structures in local communities, so that regular community review maternal deaths are implemented and incorporated in facility-level MPDSR. This is so that comprehensive data on causes of maternal deaths at every level, are identified, addressed, policies are made, and sustainable solutions created.

Secondary Recommendations

• Enforcing Guidelines and Regulations for the Operations of Traditional Birth Attendants and Other Unskilled Birth Attendants

According to the Nigeria Demographic Health Survey 2018, 61% of women give birth at home, with the assistance of a Traditional Birth Attendants (TBAs) or in faith-based centres. This is due to factors such as religion, cultural beliefs, low-income levels and poor access to health facilities. TBAs are trusted by the women in local communities. They must be better equipped and trained in identifying the danger signs in pregnancy and referring women to health facilities. State governments must ensure that the activities of unskilled birth attendants are institutionalized and regulated.

• Revitalising Primary Health Care for Better Maternal Health Care

Improving the availability, accessibility and quality of PHCs will ensure that better quality health care is obtainable for women in local communities. There should be a well-equipped primary health care centre in each of the 774 local government areas (LGAs) in Nigeria, with health care workers always present. Equipment, infrastructure and supplies such as medicines, beds, wheelchairs, potable water and

electricity must be available in every PHC to facilitate quality care.

- **Facilitating Health Education and Local Media Advocacy to Increase Awareness of Better Maternal Health Care Practices**

There is a knowledge gap in safe-motherhood and maternal health care practices among women, men and religious and traditional leaders in communities. Advocacy drives should be implemented at the community level with the help of already existing local government health education departments in partnership with community leaders and community-based organisations (CBOs). Health education must be prioritised and facilitated via a bottom-up approach from the household unit to the community level, up to the state level and on a national scale. Religious and cultural beliefs play a significant role in maternal health care practices, therefore, family units, community influencers and religious and traditional leaders should be trained to empower women to make better health-seeking decisions to present better maternal health outcomes.

- **Health Care Workers: Enabling Human Resources for Health and Patient-Centred Care**

The poor availability, remuneration and attitude of health care workers remain challenges, especially in rural and

low-resource settings where they are often working under tough conditions. State governments should deploy health care workers to where they are needed most: hard to reach communities, and offer good remuneration, hazard allowance and incentives such as free housing to health care workers who work in these areas. In terms of the poor attitude of health care workers, patient-centred care should be maintained at the core of service provided by every health care worker. Quality of care mechanisms should be developed and regulated by medical associations such as the Nigerian Medical Association (NMA).

- **State Government Commitment and Public-Private Partnerships for Better Maternal Health Care**

When the government makes policies, citizens should be informed of the policies through advocacy and community dialogue. There should be public hearings regarding some of the policies concerning health insurances schemes, for instance. For women to survive giving birth, there must be an uptake of facility attendance and for that to happen, maternal health care must be well-funded. Writing policies is not enough, policy documents must be made living guides that are converted to actionable solutions that work for women and create results that members of communities can see, feel and celebrate.

MATERNAL DEATH REVIEW OF WOMEN IN COMMUNITIES



ENGAGING COMMUNITIES TO MONITOR MATERNAL DEATHS

Despite efforts in advocacy and implementation of programs geared towards reducing preventable maternal deaths, the most vulnerable women and children in Nigeria, those in remote and hard to reach communities, are continuously faced with barriers to accessing quality health care on time. These communities lack access to medicines, health workers and infrastructure needed to meet women at their point of need. Consequently, when a woman in a community dies while pregnant, giving birth, or shortly after giving birth, there is little to no inquiry into the cause of her death.

The purpose of the maternal deaths review is to create an avenue for stakeholders and decision-makers to be well aware of the causes of maternal deaths, to address these causes at all levels by creating actionable solutions that reach the women at the lowest levels, and create policies that will ensure that women do not die while giving birth in Nigeria. Every woman, family head, community head, religious and traditional leader, ward head, state government and federal government decision-makers must realise that maternal deaths are not okay, and together, they can identify challenges and create tailored solutions for women according to their circumstances, cultural and socioeconomic factors.

Currently, the state-level implementation of the maternal and perinatal death surveillance and response (MPDSR) in Nigeria, established in 2016 is inadequate, owing to its laser focus on facility-based maternal deaths and the inability of MPDSR committees to effectively turn this data into action. This gap is what informed the approach to the review of maternal deaths in communities, with the involvement of family decision-makers, traditional leaders, religious influencers, health workers and government-level officers in inquiries, awareness and dialogue.







On **8 April 2019**, the National Emergency Maternal and Child Health Intervention Centre (NEMCHIC) was established by the National Primary Health Care Development Agency (NPHCDA) after a state of emergency was declared on maternal mortality in Nigeria. NEMCHIC was established to serve as a national coordination centre that will provide oversight on reproductive, maternal, newborn, child and adolescent health and nutrition activities at primary health care and community levels in Nigeria.

Community maternal death reviews must be included in such schemes to provide better insight into the underlying causes of maternal deaths in the places where maternal deaths occur the most: the community; far from the health facilities where the MPDSR systems are concentrated.

WHERE WE WORKED

Nigeria is a federal republic consisting of 36 states and the Federal Capital Territory located in six geopolitical zones. Each geopolitical zone comprises of states that share similar culture and history, hence our focus on one state per geopolitical zone. This was to enable inclusive insight into the maternal health-seeking behaviours, maternal health care systems and maternal health outcomes across the country.

State selection in each geo-political zone was as follows:

North-West - Kebbi State		(working in Argungu, Koko Besse and Danko Wasagu LGAs)
South-West - Lagos State		(working in Epe and Ifako Ijaiye LGAs)
North-East - Bauchi State		(working in Warji, Bauchi and Itas Gadau LGAs)
South-East - Ebonyi State		(working in Izzi, Ikwo and Ohaozara LGAs)
North-Central - Niger State		(working in Gbako, Shiroro and Kotangora LGAs)
South-South - Bayelsa State		(working in Ogbia, Ekeremor and Southern Ijaw LGAs)

HOW WE WORKED

Through the course of the year-long inquiry into maternal deaths which ran from May 2019 – May 2020, we employed data collectors already working in our focus communities, from our network of community-based organisations (CBOs) to track maternal deaths in the communities.

To facilitate the maternal death review process, we adopted a clear reporting mechanism from data collectors to programme officers that enabled us to capture data and stories of maternal deaths that they were able to document, within the communities during the review period. Data on maternal deaths in the target communities were collected weekly by the data collectors using electronic tablets. Magpi, a cloud-based tool was used by the programme officers and data analysts to analyse the data.

From conceptualisation through planning and implementation of the project, data collection, collation and analyses were considered as very central to achieving the aim and objectives of the project. Getting these three components right meant that the consortium partners were equipped to learn about maternal deaths, where they occur, why they occur and the role of communities in preventing future occurrences. It was also an opportunity for the consortium partners to give feedback to the Community Based Organisation (CBOs) and other stakeholders at the state as well as national levels.

There were consultations at different stages of the project to ensure that both quantitative and qualitative data collection tools are designed to capture information about the project. There were consultations with the Maternal and Perinatal Death Surveillance and Response (MPDSR) focal person for Lagos state. This was integral to adopting the national MPDSR form for this community data collection.

EpiAFRIC conducted a baseline assessment in communities throughout the seven states before project commencement. CBOs were selected in each state and trained on the aims and objectives of the programme by **Africare**. In consultation with EpiAFRIC, in each programme state, one staff per CBO was designated as the data focal person. These data collectors were trained by EpiAFRIC on the process of collecting quality data on maternal deaths in the communities. **Nigeria Health Watch** crafted advocacy messages that were rolled into information, education and communication (IEC) materials and were employed by the CBOs during weekly community dialogue meetings and advocacy drives.

Through the course of the year-long inquiry into maternal deaths which ran from May 2019 to May 2020, these data collectors who were already working in our programme

communities were able to effectively track maternal deaths in the communities. They engaged in weekly meetings with community influencers, and this rapport with members of the community eased the process of data collection, particularly notification of maternal deaths and collection of quality data from family members, community members and health workers present at the time of death.

To facilitate the community review process, we adopted a clear reporting mechanism from data collectors to programme officers that enabled us to capture weekly data and stories of maternal deaths that they were able to document, within the communities during the review period. Data on maternal deaths in the target communities were collected weekly by the data collectors using electronic tablets. Magpi, a cloud-based tool was used by the programme officers and data analysts to analyse the data.

Other aspects of data collection, collation, analyses and feedback include the following:

- Set up of WhatsApp group of data collectors with members of the consortium
- Periodic meetings with data collectors to review process
- Feedback at state-level multi-stakeholder meetings
- Feedback at close-out experience sharing meeting



Above: Our surveillance of the local communities allowed us to get close and personal with members of the local communities to understand what it means to give birth within the community

WHY ARE WOMEN DYING WHILE GIVING BIRTH IN NIGERIA?



In the following chapter, we deep dive into the causes of maternal deaths in the communities that we surveyed. The purpose of this state-by-state analysis is to underline the maternal health practices and outcomes in each state and by extension, each geo-political zone to inform tailored policies and map sustainable solutions to confront maternal deaths in these communities.

In the baseline survey, in every programme state, a group of women was randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions with programme officers and data collectors. The results of the baseline surveys are fully dependent on the response from the women.

According to the World Health Organization (WHO), a maternal death is the death of a woman while pregnant, during childbirth or within 42 days of termination of 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 or incidental causes.

For the sake of this **‘Why Are Women Dying While Giving Birth in Nigeria?’** report, a community maternal death is the death of a woman while pregnant, during childbirth or within 42 days of termination of pregnancy, outside of a health facility or within a health facility as a late referral from a community, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.



Above: Nafisa is one of the few women in her age group that gave birth to her first child in the primary health care centre in Itas/Gadai LGA, Bauchi State. She started attending antenatal care sessions when she was in her fourth month. She says that giving birth in the facility was helpful to her, and that she will make sure she gives birth to her other children in the health facility



BAUCHI

Pearl of the Woman

MATERNAL HEALTHCARE IN BAUCHI STATE – OBSERVATIONS

Nigeria Demographic and Health Survey

In Bauchi State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that only 21.6% of women give birth with the assistance of a skilled birth attendant. 51.6% of pregnant women attend at least one antenatal session. For postnatal care, 42% of women in Bauchi State attend their first postnatal examination within the first two days after giving birth.



21.6%

birth by skilled birth attendant



51.6%

one antenatal session



42%

attend postnatal checkup

Source: Nigeria Demographic and Health Survey 2018

Where Does She Seek Maternal Health care?

Giving Birth in Nigeria Baseline Survey

In the Bauchi State baseline survey, 17 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions. The results of the Bauchi State baseline survey are fully dependent on the response from the women that were randomly selected in Bauchi State.

Health-Seeking Behaviour

Among the women we surveyed during the baseline survey, 2 out of 5 women said that they went to a health facility for their health care needs, 1 out of 5 women said that herbal medicine was their first point of care, and 1 out of 5 women said that they visited a chemist as their first resort for health care. 1 out of 10 women said that God heals all illnesses, and that prayer is the solution to their health care needs.

Maternal Health Care

When it came to seeking maternal health care, 21% of women said that they sought care from traditional birth attendants, 32% said that they went to a health facility for maternal health care, while 47% of women said that they sought maternal care at home despite attending facility-based antenatal classes.

There is a clear disparity between the number of women who attend antenatal classes and those that then give birth in a health facility. Women in Bauchi State mostly attended antenatal care, however, when it came to the point of giving birth, they resorted to out-of-facility deliveries.

How Did The Women Die?

Giving Birth in Nigeria Community Review

From the maternal deaths that occurred during the one-year maternal review period, the largest contributor to maternal deaths was postpartum haemorrhage, contributing to 50% of maternal deaths recorded in the review. Prolonged obstructed labour was responsible for 33% of the maternal deaths recorded in the review.

Where Did the Women Die?

Giving Birth in Nigeria Community Review

Results from the review show that 75% of maternal deaths occurred at a health facility with 25% of maternal deaths occurring at home. From our inquiry into the deaths, all deaths that were recorded at the facility were late referrals from the community.

Who Attended to the Women?

Giving Birth in Nigeria Community Review

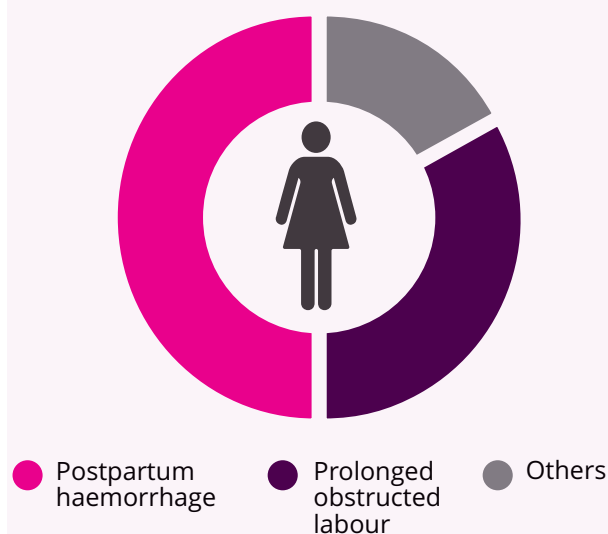
Results from the review show that an equal distribution of skilled and unskilled birth attendants was recorded among the maternal deaths recorded.



Above: A baby, her mother and her grandmother in Bauchi State. The extended family influences a woman's maternal health care decisions.

Bauchi State Overview of Community Maternal Death Review

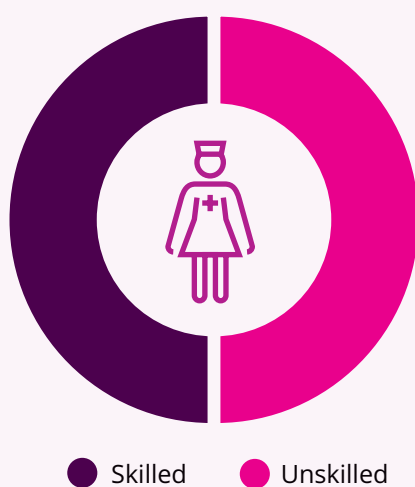
Bauchi: Suspected Causes of Maternal Deaths



Bauchi: Where Maternal Deaths Occured



Bauchi: Birth Attendants



Source: Giving Birth in Nigeria Programme

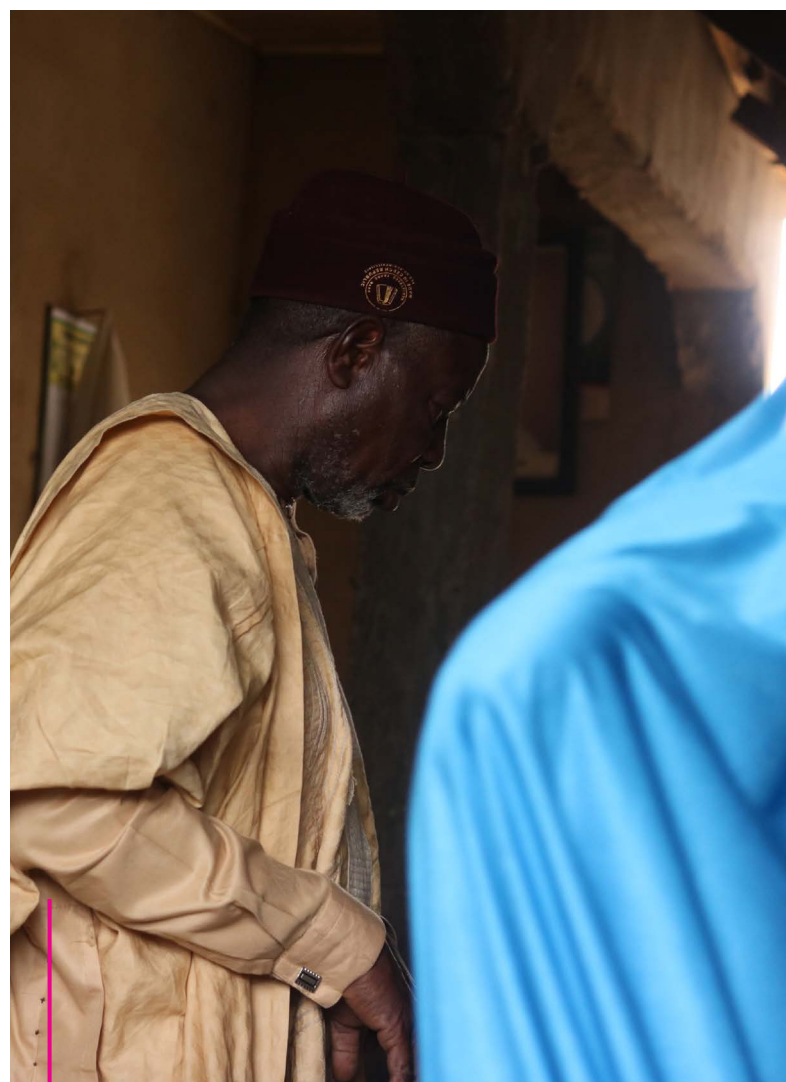
BAUCHI STATE INSIGHTS

Older Women Making Maternal Health Care Decisions at Community Level

In larger parts of the North-East, it is common to have maternal health care decisions made by a mother, mother-in-law or grandmother. These older women are important stakeholders in the community and tend to be key decision makers on when and where the younger women seek and receive maternal health care.

The Taboo of The Male Health Care Worker

A prevalent belief in Bauchi State is the disapproval by husbands of male doctors when it comes to attending to their wives. This has resulted in women being prevented from visiting health facilities to seek health care due to the predominance of male doctors over female doctors. This has resulted in adverse maternal health outcomes because complications arise when health care is administered in out-of-facility locations such as home, religious centre or by a traditional birth attendant (TBA).



Above: The Chief of a community in the North of Nigeria wields influence that can be leveraged by decision makers and solution providers in advocating for better maternal health care in the community.

Fatima's Story



Fatima lived in Bauchi State. She was the only wife of her trader husband, Aliyu. She was 24 years old. Fatima was a happy housewife. She was on her way to having her third child and was elated to discover that it was a girl, following two wonderful boys. She went into labour in her 38th week. She was scheduled to give birth at home with the help of her aunties. Time passed, the labour graduated into prolonged obstructed labour and there was no means to convey her to the nearest health facility. There were no vehicles to take her. She was taken to the traditional birth attendant's (TBA) home and was administered locally made herbs. Fatima died after 14 hours of intense labour, losing the child also. She died leaving behind a husband, two sons and aged parents.

and child health and nutrition (RMNCH+N) services in Bauchi State. It would also support the Bauchi State government to establish Maternal and Perinatal Death and Response (MPDSR) across the 320 political wards in the State.

At the time the Giving Birth in Nigeria programme commenced in Bauchi State, community MPDSR had never been carried out. The Community MPDSR was activated in July 2019 in the three LGAs of the Giving Birth in Nigeria programme implementation (Warji, Itas Gadau and Bauchi) with the input of the state MPDSR-FP, Dr Abdulmajid. Members of the committee were constituted using the National Guidelines for MPDSR in Nigeria (2015). Members comprise of government partners, TBAs, Ward Development Committees (WDC), women leaders and other community structures. Presently, community engagement is being implemented through sensitization on preventive measures against maternal deaths.

In Bauchi State, influenced by the work of the Giving Birth in Nigeria programme, there is a plan to implement multi-stakeholder collaboration in tackling maternal deaths. A commitment has been made to ensure the inclusion of traditional leaders, community influencers, religious leaders and community-based organisations in review and reports of maternal deaths in the communities. The Bauchi State Government has committed to channelling community data through the newly established State Emergency Maternal and Child Health Intervention Centre (SEMCHIC) and Local Government Emergency Maternal and Child Health Intervention Centre (LEMCHIC) which would both feed into existing state-level structures to ensure holistic data and insight, the creation of informed solutions and the implementation of plans and strategies to end maternal deaths in the State.

Government Action: Making progress in maternal health care in Bauchi State

Following advocacy and review activities implemented by the Giving Birth in Nigeria programme, the Bauchi State priorities have been enhanced. The response of the Bauchi State government to the community maternal death review model now integrates both government and community stakeholders. One key stakeholder in Bauchi State, USAID/IHP will provide integrated reproductive, maternal, newborn,

Below: Dogo and Aisha hold up the blouse that was worn by their daughter, Amina who died while giving birth to her third child. She died as a result of prolonged obstructed labour.





BAYELSA

Woman of All Lands

MATERNAL HEALTH CARE IN BAYELSA STATE – OBSERVATIONS

Nigeria Demographic and Health Survey

In Bayelsa State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that 27% of women give birth with the assistance of a skilled birth attendant, and 51.4% of women surveyed attend at least one antenatal session in the course of their pregnancy. For postnatal care, 26.5% of women in Bayelsa State attend their first postnatal examination within the first two days after giving birth.



27%

birth by skilled
birth attendant



51.4%

one antenatal
session



26.5%

attend postnatal
checkup

Source: Nigeria Demographic and Health Survey (NDHS) 2018

Where Does She Seek Maternal Health care?

Giving Birth in Nigeria Baseline Survey

In the Bayelsa State baseline survey, 15 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending

postnatal care (PNC). These women were engaged in focus group discussions. The results of the Bayelsa State baseline survey are fully dependent on the response from the women that were randomly selected in Bayelsa State.

Health-Seeking Behaviour

Among the women surveyed during the baseline survey, 23% of women cited the chemist as their main source of seeking health care, while 17% of women cited traditional healers as their primary or first stop in seeking health care. 41% of the women said that finance greatly influenced their health-seeking behaviour, and that lack of finance posed a challenge in seeking health care at a health facility. 11% of the women we spoke to in Bayelsa State said that the poor proximity to quality care prevented them from seeking better health care.

From our survey of Bayelsa State, we see that this is due largely to the topography of the state and its compounding effect on ease of access to facilities. Bayelsa State has a riverine setting, and most communities are almost surrounded by water, making it an arduous task to seek health care across the waters. These communities are distant from the main city centres, coupled with a high cost of transportation. Out of the women who found their way to a health facility, five per cent of them complained of the communication gaps between the health care workers and the patients, citing the lack of understanding of “big big words” used by the health care workers coupled with the limited communication between patients and health workers.



Above: The riverine community of Anyama, Bayelsa State, like majority of the State is completely surrounded by water. Women are relegated to giving birth within the community, left to the care of “Massagers”, or if brave to venture out, have to take a boat trip to the next town. Each one way trip costs between N600 – N1,000 and in the event of fuel shortages, can cost as high as N5,000

Maternal Health Care

When it came to seeking maternal care, 31% of women in Bayelsa State prefer to get antenatal care from traditional birth attendants, widely known as “*Massagers*”. These women are highly trusted in the community, have a long history of birthing babies for mothers and are well versed in the art of understanding the local women, hence the high patronage from women in the community.

11% of women surveyed received antenatal care from health facilities. When it was time to give birth, one in seven women gave birth with the help of a traditional birth attendant. The women said that they preferred to go to the “*Massagers*” for antenatal care because of their flexible payment plans which allowed them to pay for birth services over time.

One major point cited for the high patronage of the “*Massagers*” is that they help to carry out abortions for unplanned pregnancies without judgement. 21% of women said that they sought care from traditional birth attendants. For antenatal care, the reason stated by pregnant women in Bayelsa for not patronising health facilities was due to the perceived inability of the health care workers to treat them as well as the “*Massagers*” would treat them. In giving birth, the poor attitude of health care workers was cited by all women as the reason they would not give birth at a health facility.

How Did The Women Die?

Giving Birth in Nigeria Community Review

Postpartum haemorrhage was responsible for the majority of maternal deaths recorded in the review, contributing to 50% of all maternal deaths recorded, while prolonged obstructed labour contributed to 33% of maternal deaths and convulsions, 17% of all recorded maternal deaths.

Where Did The Women Die?

Giving Birth in Nigeria Community Review

50% of maternal deaths occurred at the home of a traditional birth attendant, with 33% of maternal deaths occurring at a health facility and 17% of maternal deaths occurring at home. Traditional birth attendants account for the majority of births and also, the majority of maternal deaths recorded in the review.

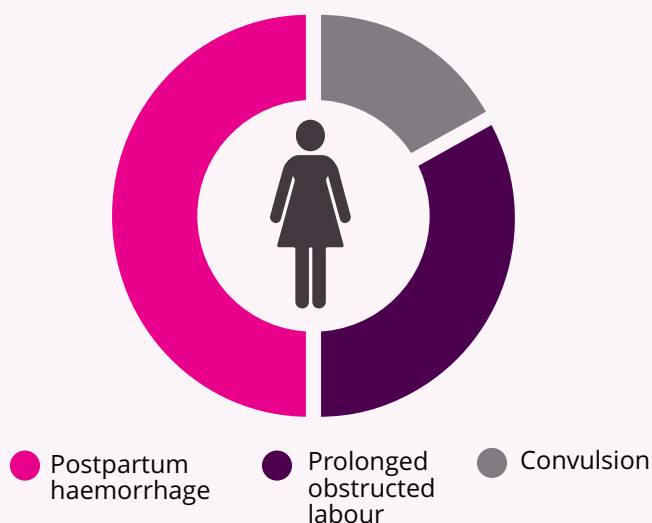
Who Attended to the Women?

Giving Birth in Nigeria Community Review

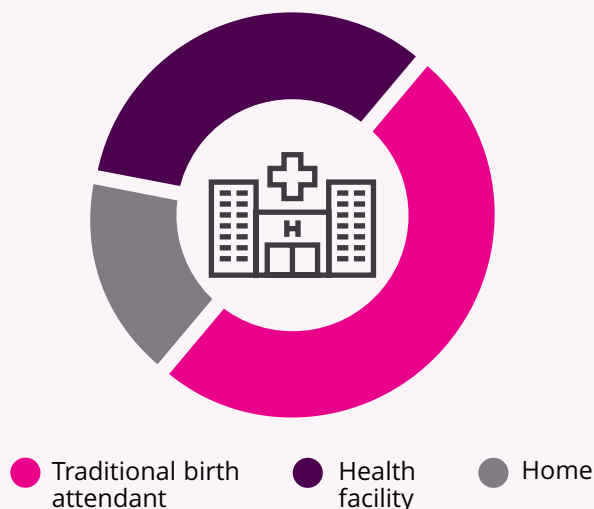
67% of maternal deaths recorded occurred under the care of unskilled birth attendants with skilled birth attendants recording 33% of these deaths under their care.

Bayelsa State Overview of Community Maternal Death Review

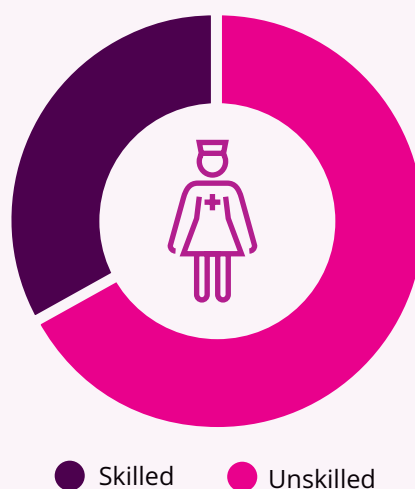
Bayelsa: Suspected Causes of Maternal Death



Bayelsa: Where Maternal Deaths Occured



Bayelsa: Birth Attendants



Source: Giving Birth in Nigeria Programme

BAYELSA STATE INSIGHTS

Working Conditions of Community Health Care Workers

Health care workers in the government-owned health facilities in rural and semi-urban communities in Bayelsa State use funds from their already stretched salaries to buy medicines for patients. When patients come in to register at the health facilities, the money paid as registration fee is used to buy medical consumables and equipment such as hand gloves, syringes and birth kits as these are not provided by the government. The registration fees charged are seen as high for members of the local communities and act as a deterrent for women who would want to visit the health facility and access maternal health care.

Also, many of the communities in Bayelsa State are riverine, making it difficult to access health care centres outside these communities. In Anyama, medical doctors posted to the riverine community refuse the posting, citing poor salary, insecurity, fear of travel by water with locally made boats and the remote and rural nature of the community. There is a health facility building located there, however there are no health care workers, medical equipment or ground amenities located in the health facility.

Attitudes of Health Care Workers and Patient-Centred Care

One major hindrance to seeking maternal health care in health facilities, cited by the women who have health facilities in their communities, is the poor attitude of health care workers. Women complained that when they are in labour

and are screaming in pain, nurses scold the women, making statements such as: ***"Your contraction is not strong enough for you to scream"***, ***"I was absent when you were making this baby, the one that made the baby with you should be here petting you, not me"*** and ***"The hospital is not your house, shut up"*** among other derogatory statements. As a result of this, women in Bayelsa State would rather seek health care from a traditional birth attendant (TBA) who is seen as more empathetic, providing support to the women when they are in labour, asking them what their needs are and assuring them of a safe delivery. The more flexible payment structures and their close proximity to the women in the community also make them a preferred option.



Ebiladei's Story

Ebiladei was somewhat of a local celebrity. What pained the local community the most about her death was that she continuously campaigned to community leaders for better health care in her riverine community in Bayelsa State. Ebiladei was 29 years old and had a fulfilling life ahead of her. She went into labour which went as normal as it could have. She was being taken to a health facility at the city centre when she gave birth in the vehicle. Minutes after, she started bleeding excessively and before she could reach the health facility, Ebiladei died.



Above: This primary health care centre built in Anyama community, Ogbia LGA has not been functional since it was commissioned. It is completely dilapidated and sits in a community where all the women resort to traditional birth attendants widely known as 'Massagers' to perform their delivery.

Government Action: Making progress in maternal health care in Bayelsa State

Bayelsa State currently faces a lot of challenges and has presented shortcomings in implementing programmes and policies that would allow for the provision of better-quality maternal health care in the state. Funding for the state MPDSR Steering Committee has not been achieved and the lack of funding continues to impede implementation of a functional maternal death review system.

There is a need for increased advocacy and awareness in Bayelsa State and Civil Society Organisations (CSOs) should be mobilized to carry out mobilization activities at the community level. The Giving Birth in Nigeria programme has spurred the state MPDSR Steering Committee in action and highlighted the need for increased advocacy in Bayelsa State to improve maternal health outcomes.

Following the community review by the Giving Birth in Nigeria programme, the Bayelsa State government identified the need for community MPDSR and has set up community maternal death reporting committees in three pilot communities: Anyama, Alebri and Amassoma. The role of each committee is to galvanise members of the communities to action. For example, if it is discovered that medication used to treat postpartum bleeding like Misoprostol is not available in the health facility or Oxytocin is out of stock, it is expected that the health facility addresses the stock out and ensure that the products are quickly replenished.



EBONYI

Woman Of The Nation

MATERNAL HEALTH CARE IN EBONYI STATE – OBSERVATIONS

Nigeria Demographic Health Survey

In Ebonyi State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that 52.1% of women give birth with the assistance of a skilled birth attendant, and 70.3% of women attend at least one antenatal session while pregnant. For postnatal care, 50.2% of women in Ebonyi State attend their first postnatal examination within the first two days after giving birth.



52.1%

birth by skilled
birth attendant



70.3%

one antenatal
session



50.2%

attend postnatal
checkup

Source: Nigeria Demographic and Health Survey (NDHS) 2018

Where Does She Seek Maternal Health care?

Giving Birth in Nigeria Baseline Survey

In the Ebonyi State baseline survey, 18 women were randomly selected from a pool of pregnant women attending antenatal

care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions. The results of the Ebonyi State baseline surveys are fully dependent on the response from the women that were randomly selected in Ebonyi State.

Health-Seeking Behaviour

Among the women surveyed during the baseline survey, one in five women cited lack of finances as the major hindrance to seeking health care. One in seven women said that the long distance to health facilities posed great challenges in getting health care from the facilities, coupled with underdeveloped road networks in rural communities which made access to health facilities challenging. However, health care workers deployed to government-run facilities usually abandoned these facilities after short periods of operation.

Maternal Health Care

In seeking maternal health care, a woman wants to be referred to as a “strong woman”. The old testament story of the Hebrew Woman is one that most of these women hold on to while pregnant. There is a widespread perception among women in Ebonyi State that only women with complications ever need to visit a health facility. One in seven women sees the health facility as a last resort in seeking maternal care.

Most women prefer to seek maternal health care from traditional birth attendants who reside and operate in the



Above: Mrs. Azubuike from Ohaozara LGA in Ebonyi State lost her daughter Nwakaego who died while being taken to the Primary Health care Centre. She had been trying to give birth at home because her husband could not afford to foot the bill for her hospital care. When the labour period became longer than usual, the TBA referred her along with her sister to the health centre. Unfortunately, she died on the way to the facility. The baby survived. She left behind four children.

community. One outstanding point for accessing maternal health care in Ebonyi State is auxiliary nurses who visit women in their homes to administer care during labour and delivery.

For antenatal care, women do not register in health facilities, but with auxiliary nurses and traditional birth attendants. These women usually register late with these practitioners, usually in their third trimester. Another source of maternal health care in Ebonyi State is the chemist. Locally, chemists are shops where medicines are sold, and first aid is given. A chemist is usually the first point of health care for a pregnant woman in Ebonyi seeking relief from pain, nausea or any other form of unease.

How Did The Women Die?

Giving Birth in Nigeria Community Review

Postpartum haemorrhage contributed to 36% of recorded maternal deaths, closely followed by prolonged obstructive labour contributing to 32% of all maternal deaths recorded. Convulsion contributed to 13% of all maternal deaths recorded in the review followed by infection from fever at 4% and complications from abortions at 2% of all maternal deaths.

Where Did The Women Die?

Giving Birth in Nigeria Community Review

42% of maternal deaths were at home, with death at the home of a traditional birth attendant contributing to 27% of the maternal deaths recorded in the review. Fifteen per cent of all maternal deaths recorded in the review occurred at a health facility. Faith-based centres and traditional healing centres both contributed to 6% of total maternal deaths.

Who Attended To The Women?

Giving Birth in Nigeria Community Review

94% of all maternal deaths recorded were under the care of unskilled birth attendants and 6% of these maternal deaths, under the care of a skilled birth attendant.

EBONYI STATE INSIGHTS

The Man – The Ultimate Decision Maker

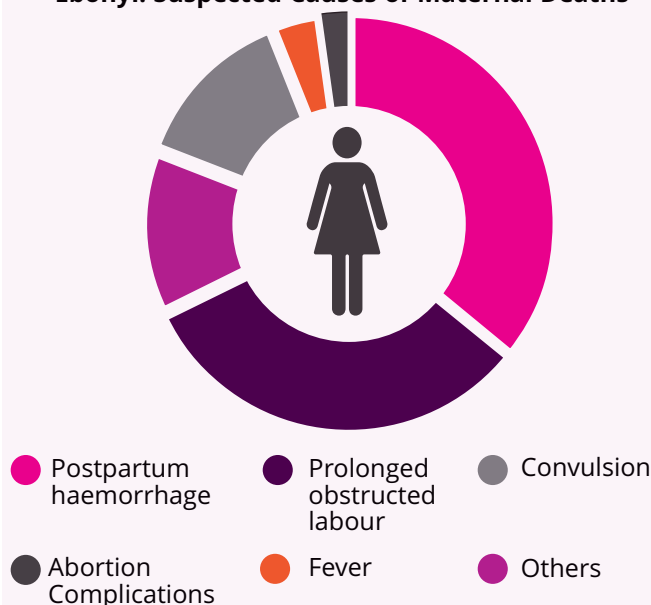
For every woman that dies while pregnant or while giving birth, there is a man that has lost his wife or partner, a family that has lost a sister, daughter or aunt. Many women in Ebonyi State do not attend health facilities without the permission of their husbands and this is a bottleneck that must be addressed if maternal deaths must end in Ebonyi State. This is a prevalent hindrance to attending health facilities for maternal health care.

The Welfare of Health Care Workers in Communities

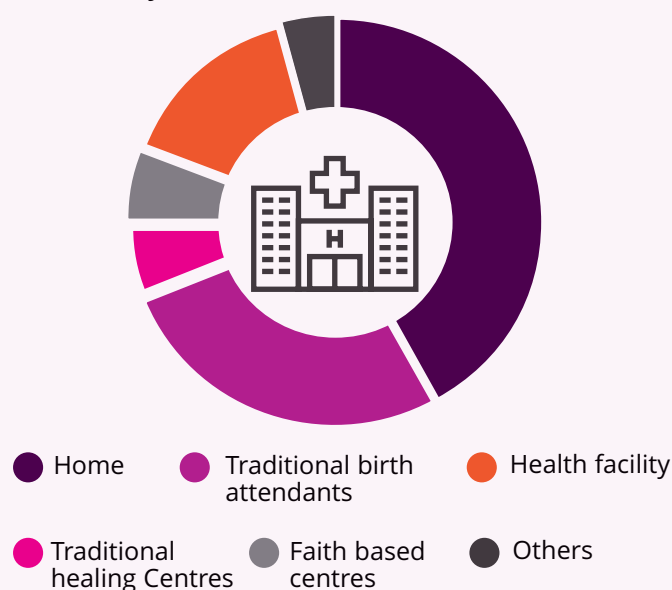
The welfare of health care workers, when posted to local communities, has been long ignored. As evidenced in our findings, health care workers have to face the challenges of poor remuneration, insecurity, poor transportation, poor

Ebonyi State Overview of Community Maternal Death Review

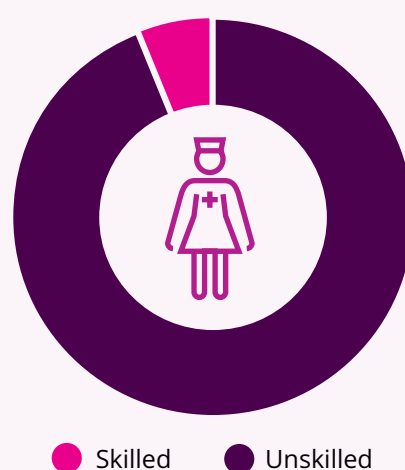
Ebonyi: Suspected Causes of Maternal Deaths



Ebonyi: Where Maternal Deaths Occured



Ebonyi: Birth Attendants



Source: Giving Birth in Nigeria Programme

working conditions, inadequate tools to work at an optimal level among other challenges. This has more often than not, led to the dearth of health care workers in local communities. When they eventually go to work in these communities, the difficult working conditions adversely affect the quality of their work and their treatment of patients under their care. Midwives are out of work but are needed in their numbers in local communities to facilitate skilled deliveries.



Obiageri's Story

Obiageri was from Ebonyi State. She was 22. She gave birth in the primary health care facility. She was discharged two days after and was met with a celebratory welcome upon her return home. One week after she was discharged, Obiageri went into convulsions. Members of her immediate family administered local herbs made from onions and palm kernel oil to stop the convulsions but to no avail. An Auxiliary Nurse was called in to attend to her but Obiageri died barely thirty minutes after she went into convulsions.

AMURT Success Story: Making Progress in Maternal Health Care in Ebonyi State

Ananda Marga Universal Relief Team (AMURT) is a private international voluntary organisation founded in India. AMURT came to Nigeria in 2010 and started a pioneer project in Ebonyi State in response to the state's high maternal death rate. Under the watchful eyes of Dala Tul Beirnsen, its Director in Nigeria, AMURT's success story for mothers in Ebonyi State has made a huge impression in the local community. In its primary health care centre in Odenigbo, one of the communities in Ikwo LGA, on average, there are 80 deliveries with 12 caesarean sections taking place at the centre each month. The AMURT story continues to achieve many successes as the Primary Health Care Centre is a lifesaver to many women. Many women from the community and neighbouring communities visit the centre especially during antenatal care classes on Fridays. "This hospital

helps us a lot", one beneficiary says. Another beneficiary sums up the impact of AMURT: "Our community has made it mandatory for all our women to give birth here."

State officials in Ebonyi State are looking to emulate the AMURT model in other communities in Ebonyi State. It is hoped that this will change the current perception that for women to give birth, it needs to be carried out at home for them to be accepted in the local society. By ensuring that women give birth with the support of a skilled birth attendant, this will reduce the number of women who die in their homes at the hands of unskilled birth attendants.



Above: The gains of multi-stakeholder partnerships for progress: The Ananda Marga Universal Relief Team (AMURT) in partnership with the Ebonyi State Government set up this Comprehensive Maternal and Child Care Centre, a well-equipped community-driven primary health care centre in Odenigbo community, Ikwo LGA, Ebonyi State.



KEBBI

Woman Of Equity

MATERNAL HEALTH CARE IN KEBBI STATE – OBSERVATIONS

Nigeria Demographic Health Survey

In Kebbi State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that only 3.4% of women give birth with the assistance of a skilled birth attendant, and 14.7% of women attend at least one antenatal session. For postnatal care, 17.6% of women in Kebbi State attend their first postnatal examination within the first two days after giving birth.



3.4%

birth by skilled
birth attendant



14.7%

one antenatal
session



17.6%

attend postnatal
checkup

Source: Nigeria Demographic and Health Survey (NDHS) 2018

Where Does She Seek Maternal Health Care?

Giving Birth in Nigeria Baseline Survey

In the Kebbi State baseline survey, 21 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions. The results of the Kebbi State baseline survey are fully dependent on the response from the women that were randomly selected in Kebbi State.

Health-Seeking Behaviour

The health-seeking behaviour of the women skewed towards facility-based care. Seventy-eight per cent of women said that they received health care from health facilities in their community. This is largely due to the increased advocacy and awareness, in recent times, of the benefits of facility-based health care. Women expressed that they preferred to go to the health facilities because they thought they received the best care there. However, two local alternative care sources still stood out among the women. Patent and proprietary medicine vendors (PPMVs) are highly patronised by women seeking health care and herbal remedies are still the first resort for relief from pain and any other form of unease.

Maternal Health Care

In seeking maternal health care, 46% of the women gave birth at home with the help of traditional birth attendants. This is a difference from other states where delivery at home and delivery with the help of a traditional birth attendant are two different processes. In other states, delivery with the help of a traditional birth attendant involved going to

their homes or birth centres while in Kebbi State, the TBAs came to the women's homes to assist in delivery. When it comes to facility-based health care among women in Kebbi State, facility-based antenatal care attendance is higher than facility-based deliveries with women choosing to attend these facilities for antenatal care, but resorting to home delivery with the help of a traditional birth attendant.

How Did the Women Die?

Giving Birth in Nigeria Community Review

In Kebbi State, the highest contributor to maternal deaths recorded in the review is infection with fever, contributing to 50% of the recorded maternal deaths. Prolonged obstructed labour contributed to 38% of all maternal deaths in the state. Postpartum haemorrhage contributed to 12% of maternal deaths recorded in the community review.

Where Did the Women Die?

Giving Birth in Nigeria Community Review

Maternal deaths were distributed between the home and the health facility. The home contributed however to most maternal deaths with 78% of all maternal deaths, and death in health facilities contributed to 22% of all maternal deaths recorded in the community review. This is a deflection from the seemingly higher uptake of facility-based births but shows that giving birth at home provides worse outcomes than giving birth in a health facility.

Who Attended to The Women?

Giving Birth in Nigeria Community Review

78% of maternal deaths recorded occurred under the care of unskilled birth attendants with 22% of these deaths occurring under the care of skilled birth attendants.

KEBBI STATE INSIGHTS

The Taboo of The Male Health Care Worker

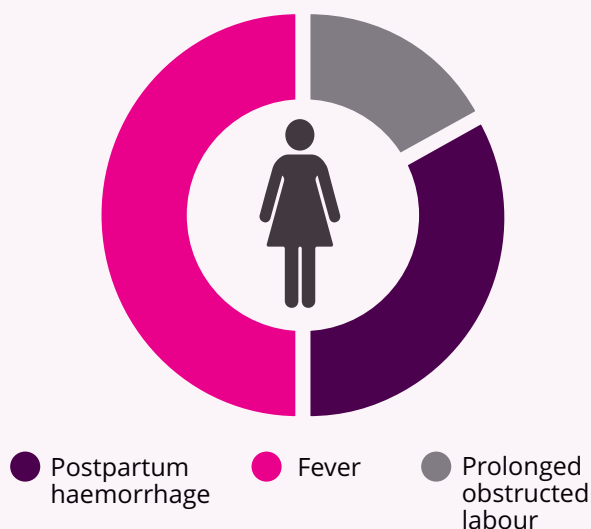
A prevalent belief in Kebbi State and from discussions with women in the rest of the North is the disapproval by husbands of male doctors to attend to their wives. This has resulted in women being prevented from visiting health facilities to seek care due to the predominance of male doctors over female doctors. This has resulted in adverse maternal health outcomes due to complications that arise when health care is administered in a home, at a faith-based centre or by a traditional birth attendant (TBA) and not in a health facility.

Providing Primary Health Care in Local Communities

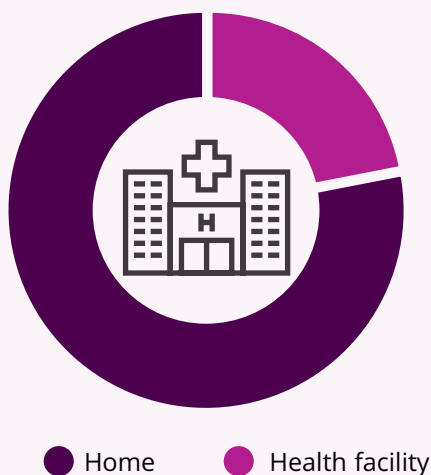
In Kebbi State, loose accountability structures to guide the establishment and operation of Primary Health Care (PHC) Centres are not implemented, therefore there exists a dearth of functional and well equipped PHCs in local communities. Access to PHCs is further aggravated by poor road networks and poor infrastructure in these communities.

Kebbi State Overview of Community Maternal Death Review

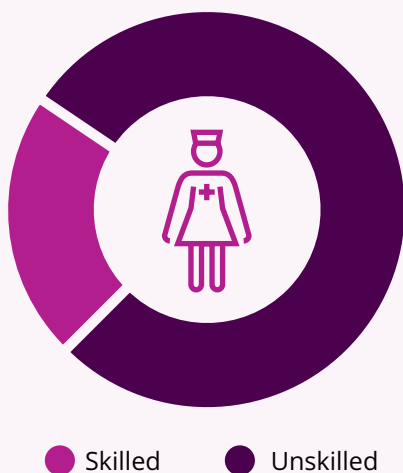
Kebbi: Suspected Causes of Maternal Deaths



Kebbi: Where Maternal Deaths Occurred



Kebbi: Birth Attendants



Source: Giving Birth in Nigeria Programme



Auda's Story

Auda was from Kebbi State. From dawn, she started suffering from what seemed like symptoms of high fever and that continued until 2:00 pm when her husband decided to take her to the nearest health facility. Unfortunately, it was raining heavily. The entrance to the village is blocked with a big valley filled up with water when it rains and can only be accessed two or more hours after the rain ceases. They were not able to leave the village and had to employ the service of the TBA. She became unconscious and could not be revived. She died by evening. Auda was 32.



Above Hauwa had just given birth to her fourth child the previous day. She gave birth in a primary health care centre in one of the communities in Argungu LGA, Kebbi State.

Government Action: Moving Maternal Health Care Forward - State-Level Collaboration

Through the Kebbi State Emergency Maternal and Child Health Intervention Centre (SEMCHIC), Kebbi State has, in the last year, embarked on improving awareness for better maternal health care practices and promoting community involvement in interventions to reduce maternal deaths in the state. One path to community accountability being carried out in the state is the selection and training of one traditional birth attendant per ward in identifying danger signs and referring the women to health facilities. There are 17 members of the State Maternal and Perinatal Death Surveillance and Response (MPDSR) Committee comprising of traditional rulers, religious leaders, representatives of transport services and private sector practitioners. The Kebbi

State MPDSR Committee engages the communities quarterly to identify issues and challenges in maternal health care and uses the insight from these meetings to inform strategy for the placement of better maternal health care amenities.

The state government has committed to addressing the shortage of health care workers, particularly midwives, nurses and doctors through a local campaign for indigenous practitioners to “come back home” and join hands to develop health care delivery. Another proffered solution to the challenge is education. [Research by UNESCO](#) has shown that if all mothers in Africa complete just primary education, maternal deaths would be reduced by 70%, saving up to 50,000 lives annually. The Kebbi State government recognises this, and in that line, posits that there is the need for more skilled female health care professionals as most men will not let male health care workers attend to their wives.



Above: A harrowing view of what would have been 'Labour Room 1' and 'Labour Room 2' at MPHCL Felande, Argungu LGA, Kebbi State



LAGOS

Woman of Excellence

MATERNAL HEALTH CARE IN LAGOS STATE – OBSERVATIONS

Nigeria Demographic Health Survey

In Lagos State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that 83.6% of women gave birth with the assistance of a skilled birth attendant, and 86.4% of women attend at least one antenatal session. For postnatal care, 72.8% of women in Lagos State attend their first postnatal examination within the first two days after giving birth.



83.6%

birth by skilled
birth attendant



86.4%

one antenatal
session



72.8%

attend postnatal
checkup

Source: Nigeria Demographic and Health Survey (NDHS) 2018



Above: Experiencing the joys of motherhood and thriving after giving birth in Nigeria must be seen as a fundamental human right of every woman.

Where Does She Seek Maternal Health Care? Giving Birth in Nigeria Baseline Survey

In the Lagos State baseline survey, 16 women were randomly selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions. The results of the Lagos State baseline survey are fully dependent on the response from the women that were randomly selected in Lagos State.

Health-Seeking Behaviour

21% of the women we spoke to in Lagos State said that poverty was a major source of worry during pregnancy, pregnancy and childbirth put further pressure on their financial resources and the lack of money prevented them from seeking better quality health care. For this reason, they resorted to faith-based homes and traditional birth attendants for care during pregnancy. Other reasons cited by the women in Lagos State are concern about unplanned pregnancies, anxiety about safe delivery and the fear of dying while giving birth.

In Lagos, 50% of the women we spoke to said that herbal medicine vendors, widely referred to as “Alagbo” are their first source of seeking health care. The Alagbo hawks liquids, powders and stems made from herbs with traditional recipes. They are widely present in all settings: rural, urban and peri-urban. One in four of these women also resort to “chemists” when seeking care, particularly when it came to relief from pain, sores or any other form of unease. Faith-based houses are highly patronised setting for seeking health care among women in Lagos State as these women believe that invoking spirits and praying for divine intervention would cure them of any illness. A health facility is the last resort for seeking health care among the women we spoke to in the communities in Lagos State.

Maternal Health Care

In seeking maternal health care, faith-based houses are the most patronised point of care for women surveyed in Lagos State. These faith-based houses are run by spiritual (or religious) leaders who provide care under the guise of divine healing as the greatest source of health care and healing. Along with faith-based houses, traditional birth attendants are highly patronised by women in Lagos State. One reason attributed to the high patronage of traditional birth attendants is the less judgmental treatment the women receive if they choose to have an abortion. Also, a similar resounding voice across the board was that teenage girls feel safer with traditional birth attendants as they experience with them, a welcoming space, free from judgement, reprimand, jeering or mistreatment. This is something they would not say of health facilities where health care workers are said to rebuke teenage girls for getting pregnant. Among the women we spoke to in the Lagos communities we visited, health facilities are the last resort to seeking maternal care and are only considered when complications arise. Gladly,

traditional birth attendants in Lagos State usually refer women to health facilities if they feel that the woman may have complications in childbirth.

How Did the Women Die?

Giving Birth in Nigeria Community Review

Two major causes, postpartum haemorrhage and prolonged obstructed labour both respectively contributed to 26% of all maternal deaths recorded in the community review. Convulsion was the second-highest contributor to maternal deaths, contributing to 23% of maternal deaths in the community review. Complications arising from abortion procedures contributed to 6% of maternal deaths, while ruptured ectopic pregnancy contributed to 5% of maternal deaths. Infection from fever contributed to 2% of maternal deaths in community review.

Where Did the Women Die?

Giving Birth in Nigeria Community Review

36% of maternal deaths occurred at home, 25% at faith-based centres and 24% of maternal deaths occurring at traditional birth attendant homes. Traditional healing centres contributed to 8% of all maternal deaths in the community review. This is a deflection from the outcome expected from the largely urban Lagos, however, from our review, we observed that the level of education of the women has little to no effect on where they choose to give birth. This is attributed to religious and traditional beliefs that are difficult to wean off, as well as and influence from family members, most especially mothers and mothers-in-law.

Who Attended To The Women?

Giving Birth in Nigeria Community Review

71% of maternal deaths recorded occurred with unskilled birth attendants with 29% of these deaths occurring under the care of a skilled birth attendant.

LAGOS STATE INSIGHTS

Poor Attitude of Health Care Workers

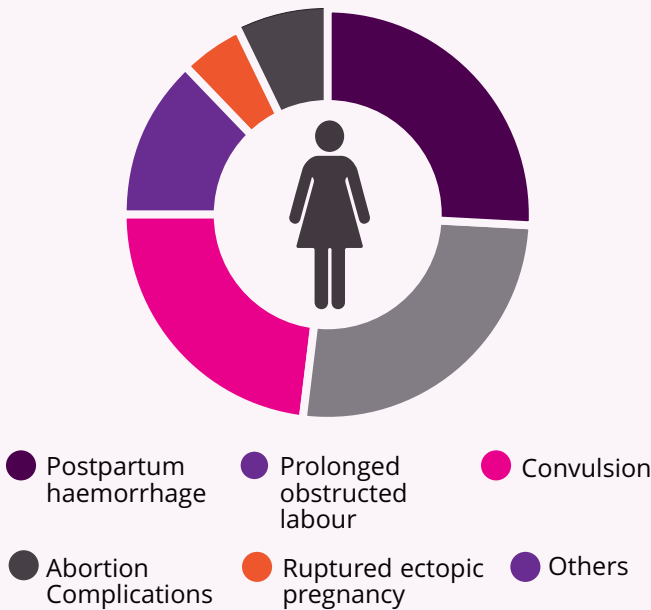
There is a significant reliance on faith-based centres over facility-based maternal health care. This has been attributed, in large part, by some of the women, to the unpleasant treatment being faced from health care workers, particularly nurses, and increasingly, doctors. The role of the health care provider is to have the right knowledge and skills to provide quality and supportive maternal health care to the woman, monitor her care and be sensitive to her needs and concerns. Every health care worker that works within the continuum of maternal health care must adhere to guidelines for care and make sure that the women get the right type of care that they need with empathy and excellence.

The Prevalence of Caesarean Sections in Private Health Facilities

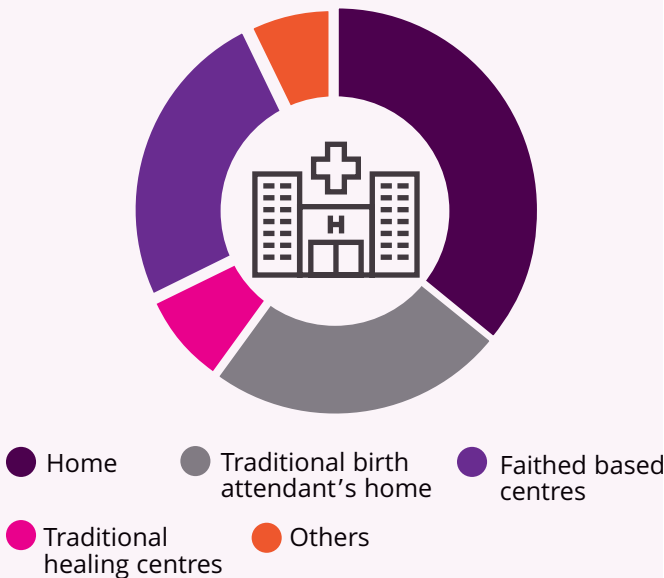
One source of worry among women in Lagos State is the fear of undergoing a caesarean section. Caesarean sections are prevalent across health facilities in Lagos State, with a

Lagos State Overview of Community Maternal Death Review

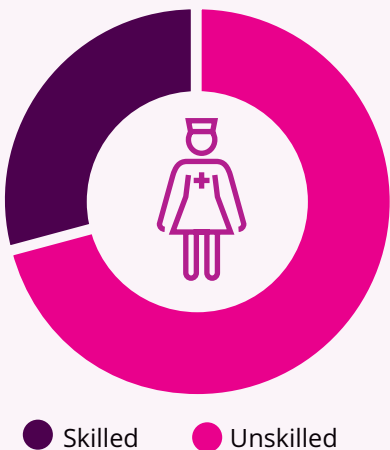
Lagos: Suspected Causes of Maternal Deaths



Lagos: Where Maternal Deaths Occured



Lagos: Birth Attendants



Source: Giving Birth in Nigeria Programme

widely held opinion among women in Lagos State that they would prefer to have the procedure done in a government-run health facility, over a privately-owned facility. This is due to the widespread belief that the privately-owned health facilities are motivated by making money from the higher cost of the procedure.

Government Action: Moving Maternal Health Care Forward in Lagos State

Since the inception of the Maternal and Perinatal Death Surveillance and Response (MPDSR) system in 2016, Lagos State has continued to implement a robust MPDSR structure at the facility level, particularly across secondary and tertiary facilities. Unfortunately, community maternal death review still lags. As a response to the advocacy efforts of the Giving Birth in Nigeria programme, the MPDSR Committee of the Lagos State Ministry of Health has carried out mobilization exercises in local communities through traditional and religious leaders as well as engaging in advocacy outreaches during cultural activities. This is with a focus on encouraging early registration in antenatal care. Also, the Lagos State Government has facilitated the involvement of Community-Based Organisations for collaboration in achieving maternal health care deliverables at community and facility levels.

The Lagos State Government, through the Lagos State Ministry of Health, having adopted the facility-based MPDSR system has committed to commencing community maternal death reviews by extending mobilization exercises to local communities through traditional and religious leaders and cultural activities. This is the groundwork of the Lagos State government's bid to form an all-inclusive MPDSR system by incorporating community maternal deaths into state records.



Bolanle's Story

Bolanle was a cashier at a supermarket in Lagos. She was 29 years old. Her older sister, whose death while giving birth was attributed to the spiritual consequence of infidelity, had died in the home of a traditional birth attendant. Her mother insisted that she give birth at a faith-based centre. Bolanle was taken to the faith-based centre as soon as she went into labour. She gave birth and shortly afterwards, started bleeding profusely. There was no effort made to move her to a health facility as the attendants resorted to praying for her. She died at the faith-based centre.



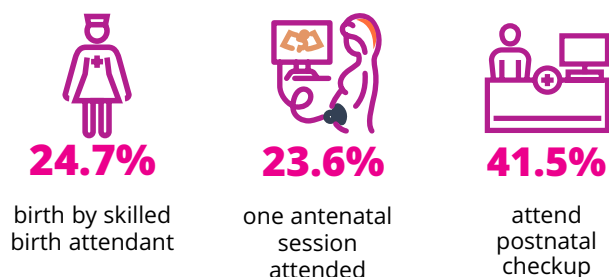
NIGER

The Power Woman

MATERNAL HEALTH CARE IN NIGER STATE - OBSERVATIONS

Nigeria Demographic Health Survey

In Niger State, according to results of the Nigeria Demographic and Health Survey (NDHS) 2018, current maternal health indicators show that 24.7% of women give birth with the assistance of a skilled birth attendant, and 41.5% of women attend at least one antenatal session. For postnatal care, 23.6% of women in Niger State attend their first postnatal examination within the first two days after giving birth.



Source: Nigeria Demographic and Health Survey (NDHS) 2018

Where Does She Seek Maternal Health Care?

Giving Birth in Nigeria Baseline Survey

In the Niger State baseline survey, 20 women were randomly

selected from a pool of pregnant women attending antenatal care (ANC) classes and nursing women attending postnatal care (PNC). These women were engaged in focus group discussions. The results of the Niger State baseline survey are fully dependent on the response from the women that were randomly selected in Niger State.

Health-Seeking Behaviour

The dearth of functional primary health care centres stood out among the women as a reason for the low facility-based care recorded. Women in Niger State cited two main sources for their health care needs: herbal medicine and the chemist. Herbal medicine is the go-to source for health care at every point of care for women in Niger State, whether initially or far into the care process. Herbal medicine providers are seen as highly effective in what they do, and women believe strongly in the efficacy of the herbs and its power to treat every type of illness.

Maternal Health Care

In seeking maternal health care, women in Niger State said that their husbands made the decisions on when and where to seek care during pregnancy or child birth. Home-based births and facility-based care were the two main sources of maternal health care among women in Niger State. Home-based births are facilitated by close family members who have history of facilitating home-based deliveries. In the case where there is a health facility in a community, facility-



Above: This is a primary health care centre in one of the communities we visited in Niger State. This is the state of many other PHCs across Nigeria. Women cannot continue to be subject to such avenues. If we are to take the woman from giving birth in the community to giving birth in the health facility, we must ensure that they are safe, secure, equipped and easily accessible to the woman.

based care seems to be the most popular option due to recent increased awareness of the benefits of facility-based care, with 66% of women we spoke to saying that they gave birth in a health facility.

How Did the Women Die?

Giving Birth in Nigeria Community Review

For Niger State, prolonged obstructed labour contributed to 67% of all maternal deaths recorded in the community review, with postpartum haemorrhage contributing to 33% of the maternal deaths recorded in the review.

Where Did the Women Die?

Giving Birth in Nigeria Community Review

From the results of this review, all maternal deaths that were recorded in Niger State occurred at home. From investigations, this is partly attributed to the scarcity of functional primary health care facilities and also, the reliance on births facilitated by traditional birth attendants who lack the skills to support women when they face complications.

Who Attended To The Women?

Giving Birth in Nigeria Community Review

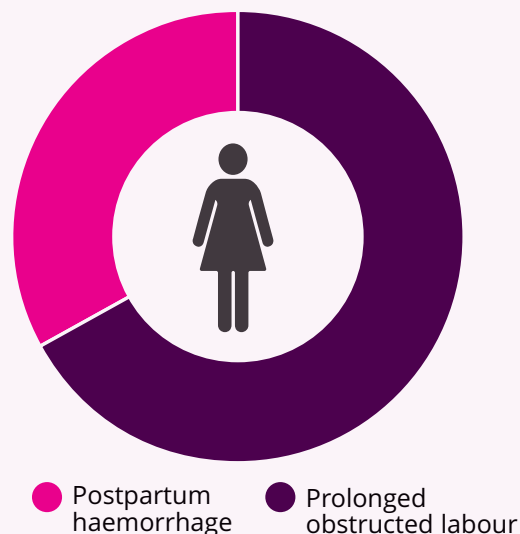
All maternal deaths recorded in Niger State occurred under the care of unskilled birth attendants, with no skilled attendant recording any death at all during the period of review.



Above: Across Nigeria, men perform the role of decision makers in households and determine household decisions including the choice of where and with whom the woman can get maternal health care. They must be included in advocacy campaigns to increase the uptake of better quality maternal health care.

Niger State Overview of Community Maternal Death Review

Niger: Suspected Causes of Maternal Deaths



Niger: Where Maternal Deaths Occured



Niger: Birth Attendants



Source: Giving Birth in Nigeria Programme

NIGER STATE INSIGHTS

Poor Working Conditions for Health Care Workers

There is the problem of poor distribution of health care workers. Every nurse, doctor or other health care worker wants to work in the state, and many do not agree to work in the rural areas. In rural communities, the number of patients is not commensurate with the health personnel available. Also, there is a dearth of midwives at the community level and posting these midwives to the local communities is a valuable initiative that will save the lives of women in communities.

Poor Attitude of Health Workers

A common complaint from the local women when it comes to health facility attendance is the poor attitude of health workers. Women should be encouraged to attend antenatal care so that the nurses are aware of their history and provide better-informed treatment for pregnant women. Health care workers face several pressures, and many are not trained on emotional intelligence to support pregnant and so, there is a missing link in patient-centred care.

Below: Women often complain of the poor attitudes of health care workers, particularly nurses and doctors and cite this as a major reason for the low patronage of health facilities. If all health care workers looked like this, wouldn't our women want to attend ANC?



Majin's Story



Majin was 41. This was her fourth pregnancy. All of her previous pregnancies had been successfully delivered at home with the help of her aunties. She went into a prolonged obstructed labour and died after pushing for hours. Her baby also died.

Community Action: Moving Maternal Health Care Forward in Niger State through Community Engagement

In Niger State, outreach activities are carried out in local communities to address key health issues that affect women's maternal health. Focus is on advocacy on better and safer birth practices, hygiene, nutrition and family planning. Community engagement on the importance of child spacing is emphasised. Religious and social organisations like the Federation of Muslim Women's Associations in Nigeria (FOMWAN), TY Danjuma Foundation and Raise Foundation among others, run weekly, monthly and annual forums on maternal health care, and contemporary issues being faced by women in the local communities.

In Gbako, one of the programme LGAs, about 200 women attend antenatal sessions at a time and 24 women at a time give birth in the primary health care centre. This is commendable considering that before the advent of the programme, there were only four in-facility births in a month. The Niger State government in collaboration with community leaders has committed to putting in place facilities and interventions to ensure that less maternal deaths occur at the community level.

MENTAL HEALTH AND MATERNAL HEALTH CARE IN NIGERIA



The Mental Health of a Woman While Giving Birth in Nigeria

The baseline data collected identified mental health as a previously unrecognized contributing factor to quality maternal health care during pregnancy and after giving birth. The expertise of Dr Ukwori-Gisela Kalu, a clinical psychologist was brought in during the survey, to assess the mental health of pregnant women and those that had given birth. This resulted in an increased focus on understanding the mental health and wellbeing of women participating in the survey.

During the baseline survey,, the team spoke to women in the southern states of Lagos, Bayelsa and Ebonyi to understand the state of their minds during pregnancy, their thoughts towards giving birth, and their expectations of motherhood. Mental health in maternal health care is often overlooked. Based on focus group discussions with the women, we see that many women face mental health challenges during pregnancy and after giving birth. Postpartum depression is just one of the many mental health challenges women face

and in recent times there is greater momentum in putting more focus on mental health, due to the bravery of women coming out to tell their stories.

Giving birth is often described as a universal experience and many social and cultural norms are based on the assumption of a positive birth outcome. Unfortunately, negative outcomes and experiences can severely impact a woman's thoughts and emotions for months and years after, especially when she finds out that no one wants to talk with her about what happened or address her fears and anxiety.

We asked the women: At what times during pregnancy do you feel especially worried or concerned?

"At all times, even until childbirth..." - a pregnant woman in Kotangora, Niger State



Above: This is Alima's first pregnancy. She does not know what will happen. In her words, "I'm looking up to blessings from Allah. It is not easy but I'm trying everyday". The mental health of a woman while pregnant and after giving birth must be a part of her maternal health care.

“Sometimes I don’t know if I will die when I give birth to the child. I am mostly worried about the day of birth. I feel worried every day, even now.”

- a pregnant woman in Izzi, Ebonyi State

“I am afraid about the day of delivery. I do not even know what I fear. Too many people have told me too many stories.” – a pregnant woman in Epe, Lagos State

Within focus group discussions and individual interviews conducted in our programme states, women reported high levels of anxiety throughout pregnancy, with little to no support services available to them. God is often referred to as their only coping mechanism for worries and fears. Also, women’s anxieties seem to be particularly focused around labour and the fear of dying while giving birth. This is often aggravated by reports of experiences of other women in their community who die during childbirth.

Giving birth at home or within a community as well as long, unaffordable and often dangerous travel to health facilities is the reality for many of the women interviewed. Furthermore, where maternal deaths occurred in these communities, women generally lacked information on the causes of these deaths, which understandably generated further fears of labour. Finally, women also reported a lack of emotional and practical support during pregnancy, particularly from

their partners, and it is apparent that the women’s mental health of the women are not addressed in any antenatal or postnatal care. Mental health problems such as anxiety disorders during pregnancy and after childbirth are serious conditions that should not be trivialised.

“The only manager of our worries is God” - a pregnant woman in Kotangora, Niger State.

“You are lucky to have your neighbour or a friend who comes to your rescue to offer some words of advice even better than your husband, otherwise you will remain helpless.” – a pregnant woman in Kotangora, Niger State.

“Thinking is one of my problems because my blood pressure is always high and when I am with my husband I don’t seem to have rest of mind because he cares less about me as the wife, he leaves the house expecting me to sort myself out, and by so doing, there is no other way to drown my sorrows than to keep thinking” - a pregnant woman in Kebbi State.

GIVING BIRTH IN NIGERIA DURING THE COVID-19 PANDEMIC

Impact of COVID-19 on Maternal Health Care in Nigeria



The highly transmissible nature of COVID-19 has been a challenge for affected countries, especially where infection rates have been rising rapidly. Expectant mothers are feeling especially anxious and vulnerable due to the pandemic, and their anxiety has been further heightened due to safety concerns around catching COVID-19 while pregnant, the potential impact on their unborn child if they catch COVID-19, potential challenges accessing health facilities and ultimately having a safe delivery. Giving birth in Nigeria has become further complicated by the COVID-19 pandemic.

IMPACT OF THE LOCKDOWN ON MATERNAL HEALTH CARE IN NIGERIA

The mandatory lockdowns instituted by the President and the stay at home directives made it harder for people to move around as public transportation was restricted. Pregnant women faced greater hardship when trying to access health facilities, to attend antenatal classes and their other routine pregnancy screenings, such as HIV or screening for other possible underlying health challenges that could affect their delivery, such as hypertension or diabetes. Pregnant women from low-income households also faced less access to nutritious foods, putting themselves and their unborn babies at further risk of premature delivery. The lockdown put further pressure on family budgets, especially where they were dependent on their daily earnings, making it harder for them to provide for their families and purchase food items.

Where pregnant women wanted to access their local health facility, many were asked to stay at home and not to come for their routine appointments, unless they had complications. It was also reported that some health facilities turned pregnant women away for fear that they may have COVID-19¹. For many women, these disruptions in access to health care caused great anxiety and health facilities did not appear to have plans to care for expectant mothers throughout the lockdowns and thereafter.

Maternal and neonatal wards also become even more vulnerable in the wake of the COVID-19 pandemic, with the need for stricter infection, prevention and control (IPC) measures. However according to WaterAid, 5.5 million² Nigerians lack access to clean water and health care facilities, and are just as challenged, with many lacking access to clean potable water³.

TRENDS IN HEALTH CARE ACCESS DURING THE COVID-19 PANDEMIC

Since the first confirmed COVID-19 case was reported in Nigeria in February 2020, the uptake of health services has been impacted, as outpatient visits have been in decline⁴. Most patients who are COVID-19 positive are taken into care at isolation and treatment centres unless they have severe symptoms. This has reduced the potential burden and pressure on hospital beds, but unlike other countries, hospital wards were not converted to accommodate COVID-19 patients, so in the short run, there has been less pressure on bed space for other patients.

Some patients who had tested positive for COVID-19 instead sought treatment at private hospitals in Lagos State, the state with the highest burden of confirmed COVID-19 cases, and one of our programme states. Many of these private hospitals were not authorized to care for COVID-19 patients as they did not have adequate safeguards to protect the health care workers in their facilities and there was also the concern that the virus could spread to other patients. As a result, many were sanctioned and shut down for a specified period. This further limited access to health facilities for pregnant women who were forced to miss out on their antenatal classes and other routine appointments.

1 <https://thenationonline.net/dangerous-fallout/>

2 <https://www.wateraid.org/uk/where-we-work/nigeria>

3 <https://www.vanguardngr.com/2020/06/why-lagos-state-is-epicentre-of-covid-19-in-nigeria/>

4 <https://www.von.gov.ng/covid-19-hospital-visits-drop-by-fifty-percent/>

Figure 1: RMNCH – Antenatal total attendance - National

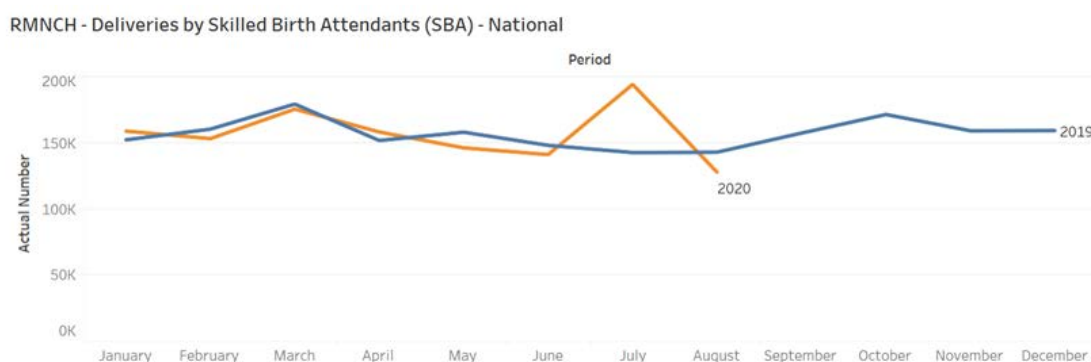


Source: NHMIS

The number of pregnant women attending antenatal classes began to fall at the start of January 2020, and when compared to the same period in 2019, it is clear that far fewer pregnant women are now attending antenatal classes across the country. There is a vast difference between the number of women who attend antenatal classes and the number of women who give birth with the assistance of a skilled birth attendant.

About one-tenth of women who attend antenatal classes give birth with the assistance of a skilled birth attendant.

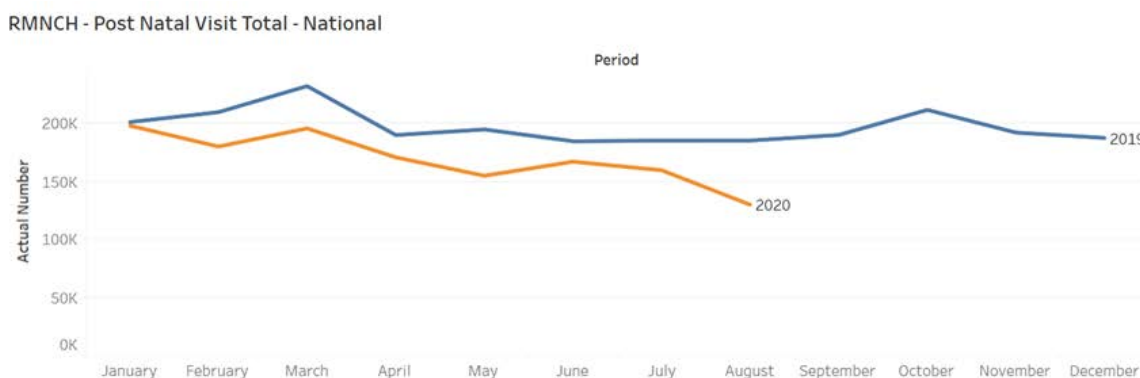
Figure 2: RMNCH – Deliveries by skilled birth attendants - National



Source: NHMIS

Due to fears of catching COVID-19, attendance at antenatal classes has been declining since the start of 2020, when compared with the same period in 2019. It is clear that fewer women are now giving birth in a health facility, and instead opt to give birth at home. Pregnant women are potentially at higher risk if they contract COVID-19, as their immune systems have been weakened due to their pregnancy. The increased number of women giving birth at home without a skilled birth attendant is an area of concern, especially if they are not attending antenatal classes. This lack of monitoring means that if they develop COVID-19 symptoms, they may not present themselves to be tested. This puts their pregnancy at higher risk and their babies also now run the risk of contracting COVID-19, as the new mothers are likely to be less aware of the necessary precautions they need to take when caring for their newborn babies.

Figure 3: RMNCH – Post-Natal Visits Total - National



Source: NHMIS

Post-pregnancy visits to health facilities have seen a significant divergence in attendance numbers when comparing the same period in 2019 and 2020. New mothers not wanting to run the risk of contracting COVID-19 or exposing their newborn babies to a similar risk are not attending post-natal care. These post-natal visits should be part of the continuum of care that they receive as they recover from their delivery.

IMPACT OF COVID-19 ON OUR PROGRAMME STATES

From this community maternal death review, there has been a recorded impact of the COVID-19 pandemic on maternal health outcomes in our programme communities and also with the work of our partner CBOs in the last two to three months of the review period (March 2020 - May 2020). Like most field projects and interventions, the COVID-19 pandemic had its impact on project implementation as field activities were suspended following mobility restrictions in the states. Data collection and community engagement activities were put on hold in the first week of April.

Our partner CBOs carried out pockets of virtual engagements with stakeholders reminding them to continue to report any case of maternal death and follow-up with community activities, encouraging expectant mothers to seek skilled health care services. In Kebbi State, our partner CBO received a report from the National Population Commission (NPoPC) Officer (also a member of the committee) of a mortality case reported by the community committee. Unfortunately, the fear of the COVID-19 reduced hospital attendance, especially for antenatal visits. Pregnant women stayed home until delivery and sought medical services only when there was an emergency.

In Lagos State, our partner CBO reported the death of a woman referred from the primary health care centre to the general hospital due to complications. Unfortunately, she was not promptly attended to at the secondary health facility due to mismanagement arising from the fear of COVID-19, and she died.

There was good news recorded in Bayelsa State, however. A teenager was supported by a community chief in Bayelsa and she was able to give birth at the primary health centre (PHC) despite the COVID-19 pandemic.

In May, about 90% of field activities were implemented. Some CBOs distributed nose masks to community stakeholders to facilitate their close-out meetings while adhering to social distancing and other hygiene practices to prevent the spread of COVID-19.

CHARTING A FUTURE WHERE MOTHERS LIVES MATTER



CHALLENGES AND LIMITATIONS OF THE REVIEW

In Nigeria, two-thirds of women do not give birth in health facilities and they give birth without the assistance of a skilled birth attendant. The health care system in Nigeria faces a lot of challenges including quality in service delivery, poor attitudes of health care workers to patients, lack of expertise, inadequate equipment, shortages in essential medicines required in health facilities, and unstable power and water supply.

Regrettably, quality data on the total numbers of maternal deaths at the community level remains an issue. The primary objective of the Giving Birth in Nigeria programme is “accountability”. A “positive anger” has been triggered to make maternal deaths in communities no longer acceptable. The primary learning lies in opportunities for collaboration, knowing that “local solutions solve local problems”, and that the fight against maternal deaths is a fight for all. Across the states, CBOs are active members of state MPDSR Committees. In Lagos State, community-level stakeholders have been accepted into membership of the facility-based MPDSR committees. The same is true in Ebonyi, Bayelsa, Bauchi, Kebbi, Niger States and the FCT. Unfortunately, the programme coverage was limited, as not all communities or LGAs were covered. However, the LGAs covered were selected to be representative of the state of affairs in each

state.

Throughout the Giving Birth in Nigeria programme, data was collected electronically, however, the GIS feature made it difficult to obtain data from out-of-station communities. On reflection, future programmes should consider and plan to engage communities virtually, should there be any challenge with community visits. The COVID-19 pandemic has drawn greater attention to the opportunities that can be leveraged in using technology to increase access to health care.

CURRENT SITUATION

Partnership and Collaboration for Better Quality Maternal Health Care

Core to the Giving Birth in Nigeria programme is the engagement of stakeholders through advocacy and dialogue to address barriers that influence access to maternal health care and positive maternal health outcomes, especially at the community level. The project leveraged on the technical capacity of State MPDSR committees, tasked with the responsibility of facilitating maternal and perinatal death surveillance and response system in states. Unfortunately, while all programme states had a state-level MPDSR committee, a few had working facility-based committees. The community component had not commenced, neither were any committees established at the start of the programme.



Left: Professional associations within communities have respective roles to play in ensuring that women have access to better quality maternal health care. Members of Okada Riders Association and National Union of Road Transport Workers (NURTW), have played a big role in creating access to health facilities for pregnant women at their points of need. State governments must collaborate with them to create and provide an even more streamlined transport network throughout local communities.

The programme, through advocacy and community engagement, created and empowered community committees to support the programme activities and implement guidelines and responsibilities of community MPDSR committees in their communities to foster sustainability.

In Kebbi State, the MPDSR committee and Road Transport workers in Wasagu community collaborated to make a vehicle available for easy mobility of women during pregnancy and postpartum to address the delay in reaching care due to distance to health facilities.

In Ebonyi State, in a bid to create awareness about the importance of maternal death reporting and advocating accountability and responsiveness in maternal health, the state MPDSR team, in collaboration with our partner CBO facilitated radio shows. Also incorporating role of the community, three community leaders from all three LGAs were actively involved in the programming to demonstrate the importance of community involvement and ownership in the maternal health chain.

In Bauchi State, the state MPDSR team during the orientation for community stakeholders committed to adopting the community committee set-up of the Giving Birth in Nigeria programme beyond programme activities. This adoption is crucial to sustainability as community MPDSR is not functional in the state. The government of Bauchi State is also looking at expansion to other LGAs, beyond our programme LGAs. Also, in Bauchi State, the Giving Birth in Nigeria programme has shaped the state response to maternal health issues through the MPDSR system using the programme as a model for community and stakeholder engagement to address the challenge of maternal deaths. A partner in the state, the USAID-IHP Project, has engaged Muslim Aid Initiative Nigeria (MAIN), a Civil Society Organisation to provide integrated RMNCH+N services. The USAID-IHP Project is supporting the state to establish community committees for maternal health across all 320 political wards.

In the FCT, the programme team collaborated with Vitamin Angels to ensure healthy pregnancy and delivery of a healthy child through the distribution of vitamins. Also, the team, with the support of Birthing Kits Australia distributed birth kits to pregnant women in Orozo and Gudun Karya Wards of the FCT.

Demand for quality maternal health care and community responsiveness

In Bayelsa State, the community committees in Anyama and Aleibiri are leading community efforts to get quality maternal health care services. In Anyama, this demand came about because of reduced utilisation of available health care as identified by our partner CBO, SynergyCare Development Initiative at the onset of implementation. The community had told them, “We don’t use the clinic because the workers are never there,” hence, the high uptake of traditional birth attendants.

The programme team facilitated engagement between the community stakeholders and officers in charge of the Primary Health Care Centre, and both parties committed to being responsible for better uptake of service delivery. While there has been a change, the attitude of health workers in the facility dwindled as no midwife was available when there was a birth emergency. While this is a setback, the team is actively engaging the LGA to provide a full-time skilled health care worker, and the community has taken up the responsibility to provide accommodation and support for such purpose to address mobility issues due to the riverine topography.

In Bayelsa State, a 19-year-old pregnant teenager was supported from the start of her antenatal care through delivery by the community chief in Aleibiri. In his words, **“I would have minded my business ordinarily, but now we know that pregnant women are our responsibilities and dying because of pregnancy is not normal.”**

Enhanced Community Ownership of Maternal Health Outcomes

In Niger State, the community stakeholders (cum committee) in Masuga have set up a fund to support pregnancy and child delivery emergencies. Lack of financial resources is a challenge in fighting maternal deaths, and the stakeholders set up this fund to assist pregnant women through outright donations or loans as the case dictates. As at August 2020, the committee had raised N24,200. Also, the committee in Masuga expanded to cover six neighbouring villages following the village head’s request.



Above: The reception of one of the primary health care centres in Niger State. The medicine table at the left corner is where women line up to get prescriptions for medicines to keep them well.

The programme engaged TBAs to know their limits in service provisions to enable more positive pregnancy outcomes. In Ifako Ijaiye LGA, the story was shared of a woman who gave birth to her first three babies at home and was pregnant with her fourth. She was taken to one of the TBAs engaged on the programme, who discovered she was bleeding. The TBA, knowing it was a danger sign, made a call to the general hospital for the provision of an ambulance for a referral. On getting to the hospital, they discovered that she had passed her due date, her placenta was rotten, and she needed an urgent caesarean section. The caesarean section eventually saved the mother and the child.

Increased access and uptake of skilled maternal health care services

The Giving Birth in Nigeria programme went beyond collecting data on maternal deaths carried out and engaged in advocacy activities to raise awareness and empower women to seek and utilise facility-based care in their vicinities. Heads of households were also engaged and encouraged to give permission and support women to use these services. Across programme states, there has been an increase in antenatal care uptake and facility births. In Bauchi State, for instance, antenatal records in PHCs in Bauchi, Warji and Itas Gadau LGAs, before the advent of the programme indicated 67, 36 and 52 women respectively received ANC services in May 2019. It later increased to a high of 104, 83 and 105 women respectively in February 2020, just before the lockdown due to the COVID-19 pandemic. Similarly, births at health facilities in Bauchi and Warji LGAs increased significantly from 30 and 25 in May 2019 to 58 and 41 respectively in February 2020.

RECOMMENDATIONS FOR ACTION

Primary Recommendation

Underscoring the Role of Community Leadership and State Government-Local Government Collaboration in Facilitating Community Maternal and Perinatal Death Surveillance and Response (MPDSR)

Traditional and religious leaders are the most influential people in communities as they function as cultural gatekeepers and guides to women in communities. They are fully engaged in resolving non-compliance in safer and better health care practices and must be involved in the drive to foster better maternal health-seeking behaviours. State governments must commit to building upon these existing socio-cultural structures to accelerate accountability for maternal deaths at the community level, through community leadership, and to advocate for the adoption of safe practices in maternal health care.

At the community level, state governments must facilitate the establishment of maternal death reporting structures that incorporate the involvement of traditional and religious leaders as they are the first point of contact by the families of the women when these deaths occur. A simple notification system at a ward office when a woman dies a maternal death should be created, as is the case for diseases like Lassa fever and yellow fever where Disease Review Notification Officers (DSNO) monitor infectious disease outbreaks at the community level. This should be facilitated by a multi-step process that includes:

- I. Family visitation
- II. Identification of a family contact person to provide a verbal autopsy
- III. Classification of the cause of death by a community-based health worker
- IV. A multi-stakeholder committee meeting to assess the contributory factors to the death of the woman
- V. Submission of data to the state MPDSR system.

This process involves a multi-stakeholder approach that would enable systemic investigation, response, action and solution. Community ownership must be elevated to ensure that no stones are left unturned and that every internal issue is adequately covered and attended to.

Community collaboration at the grassroots should be encouraged to prevent the deaths of women from pregnancy-related causes, from the household unit to the local government administrative level. Husbands and partners should bear some responsibility for the care of the woman, enabling her to access better and safer facility-level maternal health care. Members of the community should be accountable for the outcome of any woman

in their neighbourhood, supporting her through various means, such as providing transportation to enable her to access a health facility. In one of our target communities in Bayelsa State, the village head, on each antenatal care day, provides a vehicle and keeps it in a central place. All the pregnant women that have scheduled antenatal care (ANC) classes gather at a specified time and are conveyed to the health facility to attend antenatal care by a designated driver from the community. This is a prime example of communities taking ownership of the health outcomes of their women. It is a sustainable way for community leaders to ensure continued patronage of facility-based care and in the long run, end maternal deaths in the community.

Secondary Recommendations

Enforcing Guidelines and Regulations for the Operations of Traditional Birth Attendants and Other Unskilled Birth Attendants

In line with the drive for a multifaceted approach to tackling maternal deaths, sociocultural, systemic and socioeconomic issues such as the influence of family, access to health facilities and religion on maternal health-seeking decisions must be tackled alongside the strategic establishment, storage and distribution of medicines and blood banks. For example, how well do members of the community, including traditional birth attendants know about accurately estimating blood loss to the point where the woman must be referred to the health facility? Traditional birth attendants are trusted by local community women. They must be better equipped and trained in identifying danger signs and referring women to health facilities at the first sight of any danger sign. State governments must ensure that the activities of unskilled birth attendants are institutionalized and regulated. At the community, state and national levels, there must be established guidelines for the operation of Traditional Birth Attendants and other unskilled birth attendants.

Postpartum Haemorrhage (PPH) is one of the primary causes of maternal deaths among women in Nigeria. Findings from the community review of maternal deaths show that postpartum haemorrhage is the leading cause of maternal deaths among women in communities in Nigeria.. Postpartum haemorrhage was most apparent among deaths at home and at Traditional Birth Attendant (TBA) centres. The inability of TBAs to detect the onset of PPH and access to health facilities, where medicines could have been administered for the effective control and management of excessive bleeding, led to preventable deaths of women while giving birth. In the 2012 [Guideline for the Prevention and Treatment of Postpartum Haemorrhage](#), WHO recommends that women be administered uterotonic such as oxytocin and misoprostol as first-line medicine against post-partum

haemorrhage. For women in communities, this can be dispensed at primary health care level, via patent medicine vendors and through community-based pharmacists.

Revitalising Primary Health Care for Better Maternal Health Care

Primary health care in Nigeria is far from capable to alleviate the challenges that women face in giving birth in Nigerian communities. In all the states reviewed, there is, at varying degrees, a dearth of primary health care facilities that can adequately provide better quality care for women. In the riverine communities of Bayelsa State, empty buildings labelled “Primary Health Care Centre” fill the hard to reach towns and villages. In Niger and Kebbi States, dilapidated primary health care facilities are sprawled across communities we visited. In Ebonyi State, these centres exist but are not equipped with the manpower they need to deliver quality maternal health care.

Improving the availability, accessibility and quality of PHCs will ensure that better quality care is obtainable for women in local communities. There should be a well-equipped primary health care centre in each of the 774 local government areas (LGAs) in Nigeria, with doctors, nurses and midwives always present. Equipment, infrastructure and supplies such as medicines, blood banks, beds, wheelchairs, potable water, electricity and security must be available in every primary healthcare centre to facilitate quality care. These facilities should be easily reached by women, without resorting to rough terrains to access maternal health care. State governments must face the responsibility of providing better health care for women. Every State must commit to facilitating the rejuvenation of PHCs in every LGA in their State.

Improving access to well-equipped PHCs addresses the leading causes of maternal deaths recorded in this community review: postpartum haemorrhage and prolonged obstructed labour. When PHCs are equipped with quality uterotonics and health care workers with emergency obstetric and newborn care (EmONC) skills in the communities, women would have access to life-saving medicines. Also, at primary health care level, mental health support should be incorporated into Antenatal Care (ANC) and Postnatal Care (PNC) for pregnant and nursing women. Data collected from the baseline survey identifies mental health as a previously unrecognized contributing factor to the quality of maternal health care. The findings, therefore, make a case for routine perinatal psychosocial screenings as part of a holistic maternal health care programme. This plan should incorporate early antenatal and postnatal psychosocial assessments with ongoing mental health monitoring across all maternity settings. Also, there is a need for continuing professional development programs

for health care workers, which should include education about perinatal morbidity and mortality from mental illness. Finally, members of the mental health profession should be engaged in developing a standard instrument for investigating maternal deaths from indirect mental illness. PHCs must serve as lifelines for women in local communities.

At the national level, the federal government must, not just create guideline documents, but facilitate, implement and support the creation and sustained operation of PHCs in each LGA in Nigeria. Guidelines that stipulate the number and quality of PHCs per State must be published, distributed and enforced. States that fail to comply with minimum requirements in the quantity and quality of PHCs in their states should be adequately sanctioned. At the national and state levels, sustainable funding must be generated and provided for the establishment and operation of PHCs.

Task shifting was adopted by the Ogun State government in rural and semi-urban communities among Community Health Extension Workers (CHEWs) for the detection of early signs of pre-eclampsia, in Ogun State and the State recorded successes. This system should be adopted by state governments to meet the maternal health care needs of women in rural, remote and semi-urban communities. If states must measure progress and improve maternal health indices, they must equip and employ community health care workers in their communities. These community health care workers have been trained to provide primary health care to community members and should be employed to provide health care services to these community members.

State authorities including local councillors, local government chairs and state health officers must also ensure that emergency transportation systems are provided for community-facility transportation.

Facilitating Health Education and Local Media Advocacy to Increase Awareness in Better Maternal Health Care Practices

Health education at the community level, especially among the family units, men, community groups, religious groups, social groups, TBAs, traditional healing centres, faith-based centres and other places of birth in communities must be prioritised. This will help to address the challenges of religious biases as well as knowledge gaps in safe motherhood and maternal health care practices in local communities.

There are departments of Health Education in each LGA of Nigeria and they must take this charge to sit up and get to work. Educating community members about danger

signs in pregnancy, blood loss estimation, the benefit of facility-based care, mental health support for women and other maternal health determinants is key to driving better maternal health outcomes from the bottom-up. Health Education Officers have a key role in truly advancing and restructuring heightened demand for better quality maternal health care. This initiative can be facilitated in collaboration with ward officials, community leaders and other key community influencers. It is not enough to create documents and guidelines, there must be regular advocacy and awareness drives in communities, taking into cognizance the peculiarities of the communities, their health-seeking behaviours, key influences and maternal health outcomes. Women in these communities want to know more and regular community mobilization and sensitization on better maternal health practices must be carried out. They should be sensitized, along with their family members on the dangers of patronising unskilled birth attendants. Community health care workers are equally important stakeholders in driving home the message that a safe birth is the right of every woman. They must engage with women in the local communities in adopting better maternal health care practices. The AMURT model in Ebonyi State is an exemplary model of multi-stakeholder collaboration with success recorded in increased facility attendance and eventually, significantly decreased maternal deaths.

The media has a key role in passing evidence-based messages via radio, TV, newspapers and other media consumed by community members. Media practitioners have a lot of work to do in community risk communications. The media needs to educate women, in the language they understand, on their right to quality maternal health so that it can be demanded. People cannot demand what they do not know, especially if they do not know what they should be asking for.

The custodians of culture and religion have a critical role to play in ensuring that women have access to better quality maternal health care. Advocacy to traditional rulers should be prioritised so that it can trickle down to impact attitudes and beliefs at the community level, to reduce the number of women who die while giving birth. Statistics may not drive home the message, but the realities of maternal deaths abound in communities. There is a need to abolish attitudes and beliefs that put women at risk while giving birth. The culture of silence is not good enough. Religious and traditional leaders must break it by becoming advocates for better and safer health care practices. Community leaders should engage women in weekly forums to empower them to take decisions on their health care on their own. They should also be supported with the right mental health messaging. Also, to improve financial access to maternal health care, women, as part of community forums should make daily, weekly or monthly contributions, facilitated by the ward heads or religious

leaders to pool of funds that will enable them to attend antenatal classes and deliver at the health facility.

Men play an important role in improving maternal health outcomes. Many women cannot make maternal health decisions without the approval of their husbands. On another hand, younger women are also greatly influenced by older women such as their mothers and mothers-in-law. They engage in maternal health care practices passed down from the older generation of women. As a result, men and other extended family members must be included in the process of crafting advocacy and campaign messages and outreaches for maternal health. From the homes, they should be carriers of the message for better and safer health practices and this can be achieved through advocacy to the men and older women during social and religious events. Peer-to-peer groups should also be fostered at the community level to provide mental health support for women. As a recommendation for the issue of husbands refusing male health care workers to attend to their wives, families and societal institutions must empower women to take up education and careers in the medical field.

Health Care Workers: Enabling Human Resources for Health and Patient-Centred Care

Every State government must work in collaboration with health professional associations such as the Nigerian Medical Association and the National Association of Nigeria Nurses and Midwives (NANNM) operational in their States to ensure that health care workers: doctors, nurses, midwives and other practitioners are available in every LGA, adequately remunerated and protected. A policy must be set up to offer guidelines on the operation of health care workers in communities, their welfare and their output. Every State government should have a measure of responsibility in the operations of health care workers in their states. There should be national and state guidelines set up to guide the operation and welfare of health care workers in communities. Community leaders must be charged with putting in place certain measures to ensure the hospitality of the health care workers sent to work in their communities. The community members and their leaders should play a part in making the work environment more conducive for health care workers in their domains so that they can give their best.

To facilitate patient-centred care suited to the new realities of COVID-19, new models should be adopted in the provision of quality maternal health care to adequately address recommendations for physical distancing, hygiene and safety. ANC and PNC can be facilitated via telehealth mediums such as mobile apps, mobile messaging and virtual groups and sessions. Enforcing the use of simple

technology tools like SMS and video conferencing to provide telemedicine and other maternal health services is one key recommendation. Another recommendation is to ensure that personal protective equipment (PPE) are available for health care workers who must attend to women.

State Government Commitment and Public-Private Partnerships for Better Maternal Health Care

When the government makes policies, citizens should be informed of the policies through advocacy and community dialogue. There should be public hearings regarding policies concerning health insurances schemes, for instance. For women to survive giving birth, there must be an uptake of facility attendance and for that to happen, maternal health care must be funded. Writing policies is not enough, policy documents must be made living guides that are converted to actionable solutions that work for women and create results that members of communities can see, feel and celebrate. Policy documents must also be employed in creating advocacy campaigns that are easily understood by local community members and are adopted by them for better practice.

A recommendation is that state governments should key into the increased budgetary provision to the health sector through the National Health Act (NHA) and improve on funding in maternal health. Also, there must be a shift from total reliance on the government for maternal outcomes for sustainable maternal health care. Civil Society Organisations (CSOs), medical associations, media, women groups, professional associations, religious organisations, ward development committees, village development groups and philanthropists must come together to proffer solutions to the threat of maternal deaths at the community level where the majority of maternal deaths occur. Development partners should play a key role in providing technical support as well as in the provision of financial investments to enable the creation of a strategic maternal health development plan

for every state. These collaborations will feed into the government's role as custodian and coordinator of such a plan.

Civil Society Organisations are beloved by community members. This is because, with the support of donors, they provide necessities and palliatives (often financial support) to community members at stipulated intervals to aid in facilitating better health care, and as a way to assist the government in poverty alleviation. However, to create sustainable development and decrease in the number of maternal deaths in communities, the role of civil society organisations must go beyond aid and must include partnership and collaboration with state government officials, policymakers and influencers to define a minimum service package for community maternal health care in all states in Nigeria.

In Ebonyi State, the AMURT Model is proof of the ability of multi-stakeholder partnerships in fostering better outcomes in communities and driving sustainable change. The AMURT model should be proliferated through the State Emergency Maternal and Child Health Intervention Centres (SEMCHIC) and Local Government Emergency Maternal and Child Health Intervention Centres (LEMCHIC) in all states and local governments. This would create mechanisms for facilitating better quality maternal health care in local communities, taking advantage of an amalgamation of community human resources, technical resources of private sector organisations and state financial resources.

In conclusion, pregnancy is not a disease; it should not lead to death. When a woman has a chance to live, she has the chance to improve the lifetime outcome of her family, her community and her country. Women should not be dying while giving birth in Nigeria.

REFERENCES

NPC, NEMP (October 2019) Survey Data: Nigeria Demographic and Health survey.
<https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf>

UN, WHO, UNICEF, UNFPA, World Bank Group (2000-2017) Article: Trends in Maternal Mortality. ISBN 978-92-4-151648-8
https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf

David O. Akeju, Marianne V. (2006): Article: Human resource constraints and the prospect of task-sharing among community health workers for the detection of early signs of pre-eclampsia in Ogun State, Nigeria.
<https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0216-y>

UNESCO (2013): Article: New UNESCO data proves education transforms developments.
<http://www.unesco.org/new/en/media-services/in-focus-articles/new-unesco-data-proves-education-transforms-development/>

Femi Abbass, Steve. O (June 2020) Article: Dangerous fallout
<https://thenationonlineng.net/dangerous-fallout/>

Sola. O, Chioma O. (June 2020) from Article: Why Lagos State is the epicentre of COVID-19 in Nigeria.
<https://www.vanguardngr.com/2020/06/why-lagos-state-is-epicentre-of-covid-19-in-nigeria/>

Ugo Okoro (May 2020) Report: COVID-19: Hospital Visits drops by fifty per cent (50%).
<https://www.von.gov.ng/covid-19-hospital-visits-drop-by-fifty-percent/>

WHO, USAID, CHIP, MCCP, (April 2015) Article: Postnatal Care for Mothers and Newborns: Highlights from the World Health Organization 2013 Guidelines.
https://www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf

Baroness Julia .C (2013) Journal: Changing Childbirth 10 years on.
<https://www.magonlinelibrary.com/doi/pdf/10.12968/bjom.2003.11.10Sup.11753>