

## ORIGINAL RESEARCH ARTICLE

# The Society of Gynaecology and Obstetrics of Nigeria (SOGON) Plan for Sustainable Reduction in Maternal Mortality: A Review

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## ABSTRACT

In the year 2000, SOGON formulated a strategic plan on women's health based on the reproductive health approach with the aim of reducing maternal mortality by 50% by the year 2010. In 2005, the Nigerian Road Map for accelerating the attainment of Millennium Development Goals 4 and 5 was launched. One of the key guiding principles of the Road Map was promoting partnerships and joint programming among stakeholders including professional associations. In response, SOGON decided to align her strategic plan with the Road Map by refocusing the plan to the key objectives of the Road Map. The new SOGON Plan involves interventions with a focal objective of reducing the case-fatality of emergency obstetric conditions. The plan is anchored on interventions where SOGON has comparative advantage such as providing human resources and promoting capacity building for emergency obstetric care and skilled attendance at delivery, and advocacy and information dissemination on maternal health (*Afr. J. Reprod. Health* 2010; 14[2]: 139-147).

## RÉSUMÉ

**Le projet de la société de Gynécologie et d'obstétrique du Nigeria (SOGON) pour la réduction durable des décès maternels : objectifs du millénaire (ODM) 4 et 5 au Nigéria.** En l'année 2000 la SOGON a formulé un plan stratégique sur la santé des femmes basé sur la santé de la reproduction en vue de réduire la mortalité maternelle de 50% en 2010. Le Nigéria a lancé des indications pour accélérer la réalisation des objectifs du millénaire 4 et 5 en 2005. Un des principes de base clé du plan était la promotion des partenariats et la co-programmation chez les intéressés, y compris les associations professionnelles. En réponse, la SOGON a décidé d'aligner son plan stratégique sur les indications principales en reportant le plan sur les objectifs clé des indications principales. Le nouveau plan de la SOGON implique des interventions ayant un objectif focal de réduire la fatalité de cas des conditions obstétriques d'urgence. Le plan s'ancre sur les interventions où la SOGON a un avantage comparatif tel la procuration des ressources humaines pour la promotion et le renforcement de la capacité pour le soin obstétrique d'urgence et l'assistance compétente pendant l'accouchement aussi bien que la plaidoirie et la diffusion de l'information sur la santé maternelle (*Afr. J. Reprod. Health* 2010; 14[2]: 139-147).

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KEYWORDS: SOGON, Maternal mortality Reduction, Road Map, Partnerships, MDGs.

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## **INTRODUCTION**

More than two decades into the war against maternal deaths, Nigeria still has one of the worst maternal mortality statistics in the world. At 59,000 maternal deaths per annum, Nigeria is second only to India with 117,000 maternal deaths per annum, in the global estimates of maternal mortality<sup>1</sup>. India's population, however, is about eight times that of Nigeria.

Key policy documents, programmes and studies on safe motherhood in Nigeria have established common reasons for this ugly situation<sup>2-5</sup>. Overdependence on donor driven safe motherhood programmes has ensured that programmes collapsed when donor funds dried up. Lack of functional 24 h obstetric services in public health facilities in rural areas has created gaps in service delivery to the people. These gaps have been filled by unskilled birth attendants-quacks, traditional birth attendants, traditional priests, herbalists, prophets - who among them conduct over 70% of all deliveries in Nigeria. Unfavourable government policy which insists on payment for maternity services at the point of delivery has tended to drive the poor to these unskilled birth attendants. Poor transport and communication facilities in the very remote areas combined with a very low priority for safe motherhood at the local government level has further militated against the provision of skilled maternity services at the grassroots level.

Meanwhile, experience in safe motherhood programming has shown that provision of competent emergency obstetric care is the final common pathway through which all efforts at reducing maternal mortality work.<sup>6</sup> We have also learnt that programmes need to have specific and clear goals to make impact on maternal mortality reduction in the short term.

All these experiences have prompted the emergence of the idea in SOGON that a structure is needed to provide constant facilitation of the provision of emergency obstetric care at community and local government le-

vels. Even with the current level of existing physical facilities at community levels, such a structure should, at the minimum provide an organized system for capacity building for emergency obstetric care and provide consistent advocacy for safe motherhood in every local government area in Nigeria. Obstetricians are indispensable for these roles to be properly played. The new thinking will therefore necessitate a radically different role that will require that Obstetrician/Gynaecologists organize themselves to formally key into the existing health plan in every state to provide a permanent programme for building the capacity of health workers to handle emergency obstetric conditions and provide health information and advocacy for maternity care at local government levels. These activities will help to drive down and sustain existing government programmes on safe motherhood at the grassroots level<sup>7</sup>. This is a deviation from the paradigm that tends to restrict the role of obstetricians in safe motherhood to the delivery rooms.

The SOGON Plan is, therefore, based on a conceptual framework that SOGON will work with willing stakeholders in maternal health in key areas such as provision of human resources and physical facilities for emergency obstetric care at the local level through training of health workers and advocacy, activating referral and supervisory systems and advocacy to state, local government and communities for increased funding of health facilities<sup>7</sup>. The resultant improved services in public and private health facilities in rural areas is expected to increase preference for utilization of these facilities by women against services provided by unskilled birth attendants and thereby increase the proportion of deliveries that are attended by skilled birth attendants in each local government area, health district and state. Better capacity available to these skilled attendants to handle emergency obstetric conditions will reduce the case-fatality rates of complicated obstetric cases through appropriate treatment or prompt and effective referral of cases to facilities with better capacity to handle

such cases. These are expected to reduce maternal deaths from complicated obstetric conditions<sup>8-12</sup>.

The plan has specific objectives, goals and targets that can be adapted to suite the local peculiarities of individual states. The objectives include increasing deliveries by skilled birth attendants, increasing the capacity of state ministries of health to monitor maternity services, increasing the capacity of health workers to offer emergency obstetric care, increasing public awareness on issues related to maternal and newborn care and establishing a reliable data base for maternal and newborn morbidity and mortality<sup>7</sup>. SOGON will deploy to the field tools such as training, advocacy, skilled service delivery, supervision, community information/education/communication and mobilization in order to achieve these objectives. The impact of interventions for each objective can be evaluated using the targets set in the plan as benchmarks for assessment. The inherent flexibility of the plan allows each state to adjust any intervention that it deems necessary in order to achieve the objectives.

The current National Integrated Maternal, Newborn and Child Health (IMNCH) strategy which is the current government approach to reducing maternal and newborn deaths in line with the national Road Map for accelerating the attainment of the MDGs related to maternal and newborn health will require a 'watchdog' that will 'oversee' and facilitate its implementation at the grassroots<sup>13</sup>. This plan also positions SOGON to play these roles.

### **Historical Background**

From her inception, SOGON has been advancing the course of maternal health in Nigeria through research, publications, scientific conferences, advocacy and community interventional projects. Some of the interventional projects receive funding and technical assistance from donor agencies, international professional associations and companies both local and international<sup>14</sup>.

From the mid-1980s to 1990s, SOGON organized a series of workshops and seminars to raise awareness on issues relating to safe motherhood in various parts of the country. In 2000, SOGON formulated a strategic plan on women's health using the reproductive health approach. The SOGON Strategic Plan on Women's Health (2000-2010) focuses on three major issues to improve women's reproductive health: safe motherhood, prevention of unwanted pregnancy and prevention of HIV/AIDS.

Between 2002 and 2004, SOGON conducted a needs assessment survey of the status of emergency obstetric services in six states of Nigeria (one in each geopolitical zone). The report of the survey categorized causes of the persistently high maternal death rate in Nigeria based on the three-delay model<sup>15-18</sup>. Delay in managing the patient after arriving at the hospital (type 3) made significant contribution to maternal mortality with delayed referrals from facilities where patients receive initial care, lack of hospital supplies, lack of blood for emergency transfusions and lack of backup facilities like electricity as major reasons for type 3 delay. Delay in seeking health care in time (type 1) and delay in transportation to the hospital were still very significant (type 2)<sup>14</sup>.

### **Safe Motherhood Programmes: Lessons Learnt**

#### **Global Level**

Two decades of the global safe motherhood initiative has led to some greater understanding of the possibilities and challenges involved in reducing maternal mortality.

In the first decade after the launch of the Safe Motherhood Initiative in 1987, programmers learnt the vital need to have a functioning first referral level hospital, effective referral mechanisms, an information/education and communication strategy and provisions for community-based obstetrics<sup>6</sup>.

To be effective in reducing maternal deaths, the first referral level (district) hospital should have the capacity to offer comprehen-

sive emergency obstetric care including caesarean section, medical treatment of sepsis, shock, eclampsia, blood replacement, manual procedures and management of women at high risk specifically those who have had previous caesarean section and those at risk of obstructed labour<sup>6</sup>.

Similarly, an effective referral system was found to be vital to ensure that women who develop complications during pregnancy, delivery or puerperium care are moved to the nearest facility capable of offering comprehensive obstetric care. Such a referral system needs to include a means of communication between staff at the peripheral health facility and at the referral level for medical advice and feedback, a means of transporting complicated cases to referral centres and a means of coordinating care among the different levels of health care providers<sup>6</sup>.

An information, education and communication strategy is necessary to increase appropriate and timely use of services-prenatal, delivery and postnatal care and family planning, to increase awareness of the danger signs during the maternal period and to mobilize communities for transport of women with obstetrical complications<sup>6</sup>.

Equally, we now know that current efforts in safe motherhood are not based on evidence from Randomized Controlled Trials, but from accumulated knowledge and experience, including historical review of previous programmes and rational interpretation of expected benefits of specific components of the programme based mainly on clinical knowledge and common sense<sup>6</sup>. Current safe motherhood programming is based on "historical precedent, namely the pattern of maternal mortality decline in the US and Western countries and in thought experiments (logical reasoning and common sense)"<sup>6</sup>. For instance, the need for access to skilled obstetric care at delivery as a prerequisite for averting maternal death draws mostly on analysis of historical trends in maternal mortality in Western countries and on clinical knowledge<sup>6</sup>.

At the end of the second decade, more lessons have been learnt among which include the importance of generating political priority through advocacy for safe motherhood at local levels, the need for training and retraining of health workers in such areas as emergency obstetrics and life-saving skills, the benefits of focused antenatal care and the value of integration of maternal, newborn and child health care in improving efficiency, reducing cost and promoting the uptake of the different interventions by mothers and their children using the continuum of care from home to community and to health care facilities<sup>19-22</sup>.

### **National Level**

It is now known that the safe motherhood programmes in Nigeria developed no specific approach and no measurable action was to be taken<sup>7</sup>. The activities in the programme revolved around advocacy calls for improved access to quality maternal health services, prevention of unwanted pregnancy and unsafe abortion, improved education and nutrition for women and women empowerment. These involved sensitization of people and government to the high maternal mortality ratio through zonal and national safe motherhood committees who organized conferences and seminars. It also involved training of traditional birth attendants and presentation with delivery kits for cleanliness while conducting deliveries. This was a major task. These activities lacked capacity to reduce maternal mortality ratio in the short term; they also lacked specificity and focus on actual interventions that can reduce maternal deaths<sup>7</sup>. In spite of the awareness created, the government did not accept that safe motherhood was a vital and essential socio-economic investment. Structural adjustment programme was introduced into health care delivery including maternal health services. This was typified by the policy of payment at the point of service delivery.

On its part, the Preventing Maternal Mortality Network sought to reduce maternal

mortality in the short term and to evolve operational research model for use in maternal mortality projects<sup>23</sup>. Interventions were executed in West African countries including Nigeria. The project aimed at reducing the chances that complications that arise in the maternal period will result in death by providing access to good obstetric care at the facility for all parturients. It recognized that once an obstetric complication occurs, any barrier that prevents access to effective medical care increases the chances of such complication resulting in death. The PMMN used facility utilization and obstetric case-fatality rate as process indicators to assess maternal mortality projects<sup>23</sup>. It is now known that in Nigeria, the gains of the project were heavily eroded by the poor socio-economic climate which did not allow sustenance both by government and by the communities where the projects were located.

The Making Pregnancy Safer Initiative was launched in 2000 with the objective to reduce maternal mortality by 50% over ten years. The fundamental approach of the initiative was to improve conditions in the health facility to ensure good quality of care generally and especially for capacity for emergency obstetric care at the primary health care level. The strategy was to offer capacity building and adequate equipment to ensure quality delivery services and emergency obstetric care at the primary health care level and to facilitate functional referral linkage with a secondary care facility with comprehensive essential obstetric care. It is now known that the programme lacked sustained impact at local government level due mainly to lack of political commitment<sup>24</sup>.

### **The Road Map for Accelerating the Attainment of MDGs 4 & 5**

In 2005, Nigerian road map for accelerating the attainment of MDGs 4 and 5 was developed and launched by the Federal Government. The Road map provided a framework for building strategic partnerships for increased investments in maternal and newborn

health at institutional and programme levels focusing at two levels of care—health service delivery and community levels<sup>2</sup>. Special attention was focused on emergency obstetric and neonatal care, skilled attendance during pregnancy and childbirth and the essential facilities that will facilitate these. One of key guiding principles of the road map is promoting partnerships and joint programming among stakeholders including professional associations (such as SOGON)<sup>2</sup>. The Road Map noted that high dependence on donor driven programmes with periodic discontinuation following fluctuations in the inflow of donor funds is one key reason for our failure to get a good handle on the problem of high maternal mortality<sup>2</sup>.

### **Conceptual Framework of the SOGON Plan**

SOGON firmly believes that isolated hospital-based projects must now be replaced by well-planned population oriented self-sustainable programs that include all stakeholders in maternal and newborn health in each state -governments, doctors, nurses, midwives, faith-based organizations, women's organizations, community leaders etc<sup>10</sup>.

SOGON envisages programmes that must have:

- Clear-cut objectives, monitoring and evaluation
- Minimal dependence on external funding for its survival
- A mechanism for monitoring maternal mortality statistics in the environment and advising appropriate bodies when necessary
- A regular training component through regular seminars and refresher/update courses for health workers
- A communication element that should be well established to include the mass media and public information, education
- Capacity for generating political priority for safe motherhood at state and local government levels.

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The plan focuses on two major areas where SOGON has relative comparative advantage - capacity-building for the provision of emergency obstetric and newborn care (EmONC) and increasing the number of births by skilled birth attendants<sup>7</sup>. Consequently, SOGON hopes to deploy to the field the tools which obstetricians appear best trained to offer in respect of maternal health-training, education, and skilled service delivery and reproductive health research.<sup>15-18</sup> SOGON also hopes to deploy the high status and clout of its members in the general society towards organizing advocacy and social mobilization for maternal health. The SOGON Plan is a set of interventions that can be adapted to the prevailing health structure of each state.

The conceptual framework of the SOGON Partnership plan and structure is based on the principle that SOGON in partnership with all other stakeholders will facilitate the implementation of the following measures:

- strengthening emergency obstetric care including instituting 24 h obstetric services in every local government
- capacity building for health workers
- activating the referral systems
- sustained advocacy to governments at all levels
- community education and mobilization

The expected collective impact of all these measures will be increased utilization of public and private health facilities for maternal care. The rate of delivery by skilled birth attendants will therefore, increase. Emergency obstetric conditions will become better managed thereby reducing case-fatality rates for complicated cases and thus reduce maternal mortality<sup>7</sup>.

### **Goals**

The first goal is to increase the proportion of women who utilize public and private hospitals for maternity care. The essential measures for achieving this include<sup>7</sup>:

- (a) active conduct of advocacy for quality free antenatal and delivery services in every state. This measure is targeted at Type 1 delay. The programme target is 100% national coverage of quality free ante-natal and delivery services in three years.
- (b) facilitating the functionality of the two-way referral systems for maternal care. This is targeted at Type 2 delay. The activities that will achieve this include advocacy for, and organization of community-based obstetric emergency transport for all communities in every local government area, advocacy for the provision of one ambulance per local government area (LGA) by state/local government, advocacy for the provision of toll-free emergency obstetric telephone line in every LGA.
- (c) advocacy for the identification and equipment of one public or private centre, which will provide 24 h comprehensive emergency obstetric services in each local government area

The second goal is to increase the capacity of state ministries of health to monitor maternity care services<sup>7</sup>. This goal will be pursued by facilitating regular monitoring and supervision of local government comprehensive emergency obstetric care centers. An initial baseline survey of maternity services in the major district or LGA hospital should be achieved in the first 3 months. At least 4 supportive supervisory visits per LGA per year is targeted. An inventory of all delivery centres in each LGA should be completed by one year

The third goal is to increase the capacity of health workers to offer emergency obstetric care through regular training/ refresher courses on maternity, neonatal and child care for health workers<sup>7</sup>. Training for health workers twice per year per LGA is targeted.

The fourth goal is to increase public and community awareness on issues related to maternity care, newborn care and child care through regular public education on issues related to maternal, newborn and child care.<sup>7</sup>

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This will be facilitated by the establishment of a regular radio programme for public enlightenment on the state radio in the local language.

The fifth goal is to establish a reliable database for maternal and newborn mortality through conduct of a confidential no-blame inquiry into all maternal and newborn deaths<sup>7</sup>. It is targeted that a sentinel survey method of recording maternal deaths in be introduced in each community within three years and that maternal death becomes a reportable event in all LGA's in one year.

### **Organisational Structure**

The plan will be organized in a pyramidal structure with a national committee at the apex and the state (zonal) committees at the base<sup>7</sup>.

### **National Committee**

This committee is envisaged to serve as an advisory committee through which SOGON reaches out to all stakeholders at national level in order to be able to subserve the following functions:

- defining policies with regard to implementation of the plan
- liaising with the Federal government
- Raising funds from philanthropists and local companies
- liaising with other stakeholders on maternal and newborn health
- Supervision and evaluation of programmes across the states

The committee is to be headed by the President of SOGON and it shall be made up of all national officers and sector chairmen of SOGON, representatives of the Paediatrics Association of Nigeria, National Association of Nigeria Nurses and Midwives (NANNM), Faith based organizations, Non-governmental organizations and donor agencies.

### **State (Zonal) Committees**

Each state shall have a zonal committee. The state zonal committee shall constitute the hub of the SOGON plan. The zonal committee shall be responsible for liaising with state governments for the purpose of plugging the SOGON plan into existing health programmes, structures and plans. The zonal committee shall be made up of major stakeholders in maternal and newborn health. The committee will select and deploy a SOGON member who shall be known as SOGON DISTRICT FOCAL PERSON to each senatorial or health district.

The district focal person shall have the following functions:

- overseeing the activities in the plan in a specified health or senatorial district
- working directly with safe motherhood committees at local government and ward Levels
- working with the inspectorate and supervisory units in the state ministry of health
- organizing advocacy, community mobilization and education, training of health workers, operational research activities
- maintaining data on maternal and newborn morbidity and mortality

The position of focal person shall be rotated among SOGON members in each state. The focal person will report quarterly to the state committee. The focal person will draw stipends from SOGON or the state government for running expenses.

### **Monitoring and Evaluation**

Monitoring and evaluation of the programme in the state will be organized by the state zonal committee using the set targets as benchmarks for assessment and relying on regular reports of the SOGON focal persons, results of surveys to be conducted, records of health facilities as well as the minutes of the meeting of safe motherhood committees. Also the national committee shall have supervisory mandate over all state committees

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and shall organize, through its subcommittees, evaluation of the extent of the accomplishment of the objectives of the plan in the states.

### **Strengths of the SOGON Plan**

1. The plan is consistent with recommendations of previous surveys, programmes and strategies on safe motherhood
2. The plan is consistent with the national road map for accelerating the attainment of the millennium development goals 4 and 5 and with the current Integrated Maternal, newborn and child health strategy
3. The plan makes use of existing structures and does not create parallel structures
4. The plan incorporates public-private partnership as well as community participation for providing maternal and newborn care

### **Weaknesses**

1. A stable political and economic climate that will facilitate stable government policies is critical to the success of the plan
2. Lack of commitment by SOGON members will be a serious impediment to success.
3. If state governments fail to provide the little funds required for the programme, this will negatively affect implementation

### **CONCLUSION**

Efforts have been made in the preceding paragraphs to highlight reasons why the Society of Gynaecology and Obstetrics of Nigeria (SOGON) responded to the national Road Map for accelerating the attainment of the millennium development goals related to maternal and new born health and why SOGON deemed it necessary to document how her Strategic Plan on Women's Health will be able to facilitate the implementation of the National Road Map. The resultant plan is referred to as the SOGON National Plan for Sustainable Reduction in Maternal and Newborn Deaths in Nigeria which was launched

in Abuja in February 2008. The SOGON plan is not a parallel programme to the Road Map or any other plan of government necessary for the attainment of MDGs 4 and 5. Rather it is a process of facilitation of the Road Map. It draws heavily from lessons learnt globally and nationally in safe motherhood programmes since the Nairobi Conference in 1987. It can be a rallying point for all professional groups involved in maternal and new born care in Nigeria namely Obstetricians, Midwives and Neonatologists. It provides a framework to deploy these professionals to the field to ensure that government programmes are sustained at the grassroots level. The thrust of the plan is increasing skilled attendance at delivery through capacity building for emergency obstetric and newborn care (EmONC), advocacy, information/education and communication on maternal health care at community level which will, among other benefits, make public health facilities attractive and competitive enough to lure women away from unskilled birth attendants. In these areas, obstetricians have a comparative advantage over any other group and constitute the best resource base for implementing those aspects of the National Road Map.

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