MP 4
Women and Children
A quarterly publication addressing maternal, newborn and child health in Nigeria

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"Procreation should not be a death sentence...save our mothers!"

Paying attention to hospital standards would save more women's lives. Insert: Prof. Emmanuel Dipo Otolorin of ACCESS Nigeria..

Just as grieving families bemoan the unnecessary deaths of their sisters and wives, more non-governmental organizations and professional associations are joining the advocates of safe maternal, newborn and child health in asking for better quality healthcare system and an integration of every related maternal and child health policy.

Professor Emmanuel Dipo Otolorin of JHIPEGO and ACCESS Nigeria bares his mind in this interview with *MP4*.

MP4: How do you see the state of maternal, newborn and child health in Nigeria?

Prof. Otolorin: It is most disturbing that we lose more than a hundred women as a result of pregnancy, child birth or post partum complications everyday! We will take it very seriously if we equated it to a plane-load of Nigerians crashing everyday without survivors!

But unfortunately these women are dying quietly in the nooks and crannies of this country, in homes, on the way to the health facilities without emergency obstetric care.

They die from simple things like hemorrhage, eclampsia, prolonged or obstructed labour, unsafe abortion and all kinds of other things that can be prevented. They die quietly and in pain and are being replaced in every part of the country.

Now we are saying that this is not satisfactory! Nigerian's contribution to global maternal mortality ratio is 10%, whereas our contribution to the world's population is only 2%.

In other words, we are contributing more maternal deaths to the world than we are contributing to the population. So the whole situation is embarrassing especially because it is something that can be easily avoided.

Can you give us more insights into the performance standard guideline being spearheaded by ACCESS, along with the FMOH?

The development of performance standards for Emergency Obstetrics and newborn care was something that ACCESS suggested and worked with the Federal Ministry of Health to develop. One of the things on the FMOH road map towards the achievement of the MDG goals is the development of standards and protocols that will guide the quality of care in Nigerian health facilities.

ACCESS took the initiative, organized a series of stakeholders' meetings bringing together federal ministry of health officials, state ministry of health officials, local government officials, Nigerian medical and Dental health officials, professional associations like the Midwifery Association, Pharmacists, laboratory scientists and some development partners like USAID, WHO to look at the interventions necessary to achieve quality health care for EOC and agreed on the standards that we would like to see.

If you use these standards to assess our health facilities, you will find out that many of them do not meet these standards. For example, we have standards on antenatal care, standards on labour and child care, standard on postnatal care, standard on newborn care,

"Trying to continue the procreation of human beings should not mean that we should let them just die and be forgotten. Health is wealth. We must save our mothers."

-Professor Emmanuel Dipo Otolorin, Chief of Party ACCESS Nigeria

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standard for management, standard for support services and so on and so forth. We have 199 of them for hospitals and 173 standards for primary health care facilities. Now it is left for each hospital to take these standards to assess themselves, find out where they are, find the gaps and the things they have to do to solve them one by one. Some things will be easy for them to solve like buying soap to wash your hands, like buying gloves to be worn when they are conducting delivery. Other things may be a little bit of a challenge such that they will require help either from the government or even from corporate bodies.

It is only the Nigerian medical council that has the power to actually sanction hospitals that are performing below standards. So I would hope that since the Nigerian medical and dental council contributed to the development of this document, that they can use part of this document to actually access institutions and sanction those that are not performing according to those standards.

For how long has ACCESS worked in northern Nigeria and what has been the impact?

ACCESS is a USAID-funded programme, whose primary objective is to reduce maternal and newborn mortality in northern Nigeria. The focus is on northern Nigeria because the maternal and newborn mortality rate is like ten times what it is in southern Nigeria. So if we are going to reduce maternal mortality in Nigeria as a whole, we first have to reduce it in northern Nigeria. This is why the ACCESS programme is focusing on northern Nigeria, starting in two States: Kano and Zamfara.

What we are doing is a two-pronged approach; mobilizing communities to be aware of the danger signs in pregnancy, during childbirth, after delivery, and even for the newborn, thereby indirectly encouraging institutional delivery. In other words encouraging them to go to health facilities for antenatal care as well as for delivery care.

The second prong of our programme is to improve the quality of the care women will receive when they do go to the facilities by training the health care workers at the facilities on evidence-base interventions. We are also upgrading some of the health facilities, using our standard-base management and recognition approach to identify gaps in the quality of care and jointly find solutions. The whole objective is that working together with the community, local government and state governments, we can improve the quality of care in these health facilities.

How do you think other sectors of the economy can contribute to reducing maternal, newborn and child mortality since it cannot be achieved by the health sector alone?

I will like to use this medium to appeal to the numerous cooperate organizations we have in this country to consider funding emergency obstetric and newborn services as part of their corporate social responsibility. What stops MTN or GLO or CELTEL from helping to provide water in a hospital where they don't have water. I know it is the government's responsibility but these corporate organizations will eventually get the credit for it. People will recognize that it was, say MTN, which dug a borehole facility and brought water to their facility so that health care workers can wash their hands before attending to patients. If GLO comes to a facility and provides them with surgical equipments to be able them to do caesarian sections, people will be grateful to GLO.

We will like to call on our private cooperate bodies to think of health care deliveries and make contributions to save our women from dying unnecessarily in child birth and after delivery. Leadership is about serving the people. So leaders should not miss the opportunity to take bold decisions that will let them be remembered; to put a legacy in place such that people would say 'when X was there, he contributed to the reduction of maternal and newborn mortality in this particular area or zone'.

3rd Africa Conference on Sexual Health and Rights

"We should not necessarily have to die or suffer as we exercise our sexuality. We should stick up for the woman, for the positive sexuality practices that fulfil our lives to procreate safely."

These words, spoken by Dr. Uwem Esiet, Convener, African Federation for Sexual Health and Rights, reflect part of the focus for this year's 3rd Africa Conference on Sexual Health and Reproductive Rights. Reducing maternal mortality is a key issue of the conference, with presentations on maternal mortality which would enable participants who are interested in reducing maternal deaths to see what has worked in the past and apply these methods in their own countries and communities, while, at the same time, downsizing what has not worked.

Convened by Action Health Incorporated (AHI) under the sponsorship of the African Federation for Sexual Health and Rights, the 3rd Africa Conference will examine the interrelationships between poverty and sexuality and how the issue of accountability affects sexual health and social well-being in Africa. Special attention will be granted to the issue of accountability including fiscal responsibility in sexual health and rights work, ensuring equality of access to sexual health information, and rehabilitation of victims of rights abuses.

No less than 500 delegates from over 25 countries will come together in Abuja, Nigeria for this year's conference. The event from January 3-7 will be held at the prestigious Abuja International Conference Centre and features a keynote address from Elizabeth Mataka, the UN Secretary General's Special Envoy on HIV in Africa.

Professor Babatunde Osotimehin, Director General of the Nigeria National Agency for the Control of AIDS (NACA), will lead the range of panel discussions as the Conference patron.

According to Esiet, the main goal of the conference is to catalyze understanding of sexuality, both within the continent and outside the continent. His words: "It is a singular opportunity to reflect on where we are as far as sexuality is concerned and to assess our personal and organizational accountability to improving our understanding of sexuality."

Youth involvement is also at the core of the conference, with side events such as youth sexuality discussions sponsored by IPPF, IPAS, IWHC, and AHI to promote dialogue between adults and youth on sensitive issues such as sexuality education, sexual violence and abuse, gender roles and traditional practices.

MALARIA:
The unseen danger in pregnancy

Malaria has become very important globally because of its effect on the economy of nations. Its effects are made more manifest through its impact on pregnant women and children less than five years of age. Each year, more than 45 million women become pregnant in malaria endemic areas including 30 million in Africa.

In Nigeria, the near universality of marriage, the low utilisation of contraceptives has led to a high Total Fertility Rate of 5.1. This implies that with each additional pregnancy and childbirth, a Nigeria woman faces an even greater risk of experiencing malaria complications that can result in disability or death. Malaria in pregnancy in high endemic settings like Nigeria may account for 3 - 5% of neonatal deaths, up to 14% of low birth weights and up to 15% of maternal anaemia.

It is known that women of reproductive age have little acquired immunity in areas of unstable malaria. The consequences of this include: frequent maternal illness due to malaria, increased frequency of severe malaria with central nervous system complications, maternal anemia, stillbirths, abortions, and congenital infections. Other consequences include hypoglycemia, hyperpyrexia, severe haemolytic anemia, jaundice, and pulmonary edema.

Pregnant women are more susceptible to malaria than non-pregnant women; probably because when pregnant, a woman loses some ability to fight infection. It is also difficult to recognize malaria in pregnant women as many of them do not exhibit the classic symptoms, such as fever. It is also on record that at times, the blood tests come out negative because the parasite in the blood of the mother hides in the placenta so it does not appear in a finger blood sample.

Recognizing malaria as a common enemy to humanity, especially to pregnant women and children, Dr Yemi Sofola, the Coordinator of the Nigeria Malaria Control Programme has called on all tiers of government, countries, partners and stakeholders to take action to address the issue of malaria and to collectively make efforts to eliminate malaria.

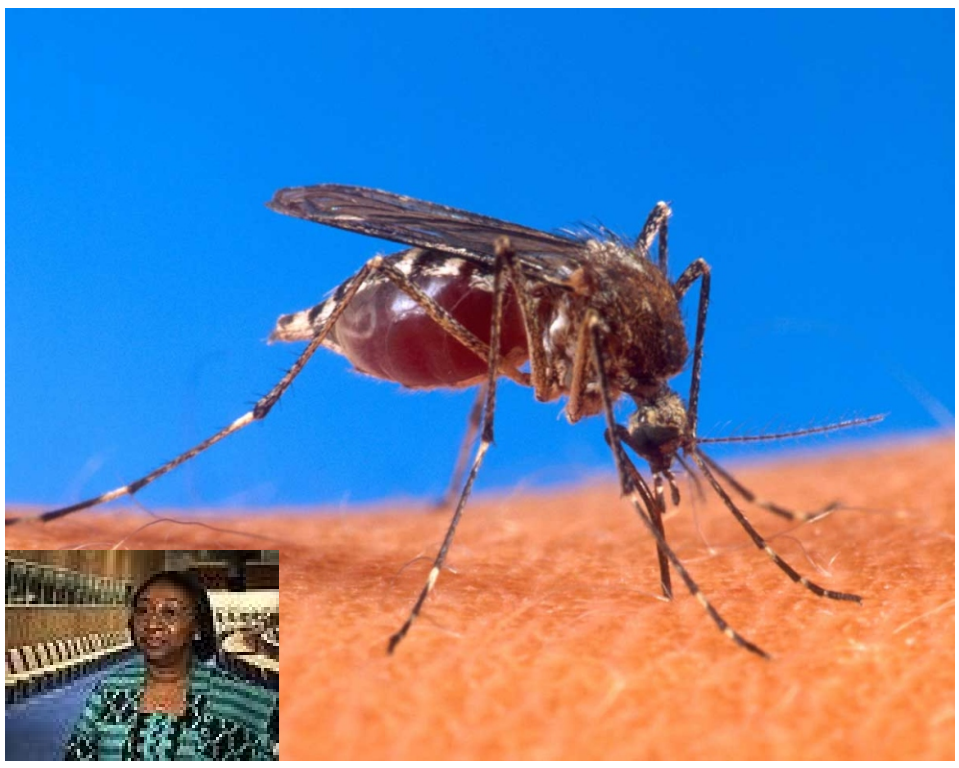
While speaking at the national review meeting for malaria programme managers at the Gateway Hotel in Ijebu-ode Nigeria recently, Sofola stated that the devastating effect of malaria has not only laid a heavy burden on the gaunt health system in Nigeria but has also diverted funding priorities creating huge gaps in the national development.

As such, the Nigeria National Malaria Control Programme is employing a workable and evidence-based framework for the elimination of malaria. The framework for malaria control is multi-pronged with four strategies.

The first strategy is ensuring antenatal care and health education of all pregnant women who avail themselves of the government antenatal care. At every visit, health personnel enlighten the pregnant woman of the various health dangers and risks she is exposed to and proffer different means of reducing or completely eradicating these risks.

The second strategy is Intermittent Preventive Treatment (IPT), which assumes that a pregnant woman is infected with malaria and as such should receive at least two treatment doses of anti-malaria drugs--whether or not they have the symptoms--or a positive blood smear.

The IPT also entails treatment with Sulfadoxine-Pyrimethamine (SP), which is a single dose of 3 tablets that must be taken at once and under direct observation. SP is generally more effective now than chloroquine due to increasing resistance to chloroquine. Under the IPT, the first dose of tablets should be administered between the 4th and 6th months of pregnancy while the second dose of tablets is given between the 6th and 8th months.



For pregnant women, this small mosquito can mean big problems. Insert: Dr. Yemi Sofola, Coordinator of the Nigeria Malaria Control Programme..

It is advocated that pregnant women should be educated on the need for this treatment even when they are not exhibiting malaria symptoms. This will ensure that they understand the importance and will come back for the next dose to ensure full compliance.

They are also to be told beforehand of possible side effects including mild headache, nausea, and some skin and mucous membrane reaction (Stevens Johnson Syndrome).

The use of Long Lasting Insecticide-Treated Nets (LLINs) is the third strategy in the framework for malaria control. The use of LLINs has been shown to reduce malaria transmission by physically preventing mosquitoes from landing on sleeping persons. This has led to a smaller number of pregnant women having malaria and consequently to a reduction of babies born of low birth weight or prematurely.

Pregnant women are also advised to: wear clothing that covers the arms and legs, install mosquito screening in windows of their houses, and clear bushes around the house and drain free-standing water.

Case Management is the last strategy of the framework and comes into play after the aforementioned ones fail. Case management emphasizes on screening and prompt treatment for anemia. This stage is when the pregnant woman is diagnosed to have malaria and is in urgent need of medical assistance.

While this situation is not a welcome one for health workers, there are enough competent hands in the health facilities to handle this condition. As such women are advised not to embark on self medication. They are also advised against patronizing roadside chemists as they may not know the point at which to refer or what exactly to diagnose.

Dr. Yemi Sofola opined that with the rising profile of malaria, the current bottlenecks being experienced at the state and local government levels will soon be overcome and the expected output and outcomes of interventions met to halve the burden of malaria by 2010 and a malaria-free Nigeria by 2015.

CEDAW
and the silent screams of women

CEDAW is the acronym for the Convention on the Elimination of All Forms of Discrimination Against Women (**CEDAW**).

It is an international human rights document, which promotes the principles of non-discrimination and equality between women and men, of which Nigeria is a signatory to.

The domestication of CEDAW in Nigeria has been in the limelight quite a while because of the diverging views from different sectors of the Nigerian society. While some people view it as a purely abortion law, others are saying that it seeks to uplift the quality of life of Nigerian women. Some of the articles in CEDAW include:

Article 1 which defines discrimination to mean distinction, exclusion or restriction on the basis of sex in the political, economical, social, cultural, civil or any field. Women and men should be treated the same way in every aspect of life. This applies to both married and single people.

Article 16 states that women and men have equal rights in marriage and family relations. Women therefore have the right to: marry and freely choose their spouse; have a divorce if they so desire; have equal rights; share the same parental responsibilities as men; decide the number and spacing of their children; own and give away property; and choose their profession or occupation.

In Nigeria, the discriminatory actions against women include male-child preferences, which has been known to lead to the withdrawal of the girl-child from school to get married when there is paucity of funds to educate the children; refusal to educate the girl-child because of the thinking that she would end up in a man's bedroom with no tangible means of livelihood; and female genital mutilation which increases the risks of pregnancy and child birth complications later in life.

There are also the aspect of depriving the widows and daughters of their husband's and father's assets, the payment of higher taxes by women, and widow inheritance.

Married women are still being discriminated against in employment and under the tax policies. Women have to prove "beyond reasonable doubt" that they are the breadwinners in the homes before being allowed the tax relieves. Some women are denied employment for being of childbearing age. Girl-children are still being given away in marriage, perhaps because the Nigerian constitution endorses child marriage by treating a married child as an adult. Section 29(4) states "Any woman who is married shall be deemed to be of full age".

In the absence of the domestication of CEDAW, women are still dying by their thousands in Nigeria.

More girls continue to have their genitalia mutilated and deformed at the insistence of their fathers who are well grounded in 'our tradition and customs'. Families are still selling their girls to the highest bidders who can afford to pay their 'cut throat' bride-price.

In Nigeria, there are about 1000 deaths for every 100,000 live births. Some of the reasons for this include: the very young age of the women; arriving at the health facility late because the husband was not around to grant the permission; non-attendance of antenatal clinic due to ignorance; and financial constraint since the women are solely dependent on their husbands.

The above does not absolve the government of its obligatory role to providing quality healthcare systems to its citizenry, providing good and effective support systems such as good roads, good transport system to ensure that these women do not continue to die unnecessarily.

Women are often forced to sit and wait for their husband's consent to seek medical care for themselves or their children.

While the argument on CEDAW continues, who takes care of these women? The argument is hinged on semantics: the use or non-use of the word 'abortion'. The fight has been ongoing long enough yet many young Nigerian women are still being discriminated against.

The society, the police and even the law are perpetuating these discriminations. A man is told to go and settle his family matter when he should be charged for wife battery, a child rapist is charged for defilement, fathers still give their daughters to friends as wife, women still die from too many pregnancies looking for the elusive son, girls are still not enrolled in school because it is of no use when she marries, women still have to await their husband's permission (financially and otherwise) before accessing antenatal care.

Who fights for these women for whom people are arguing legalities on the pages of newspapers? Who hears their silent scream and come to their rescue since it seems the government has abandoned them to the hands of fate while their culture and traditions have turned their backs at them?

The major interest of CEDAW is nondiscrimination against women and girls and some of the areas of focus are health, violence, globalization, economy, human rights and political empowerment based on the principle of eliminating discrimination against women and girls.

Instead of wasting time on semantics and falling back on tradition and religion, Nigeria should work towards the practicalisation and full implementation of the ideals of CEDAW in Nigeria.

MP4 Women and Children

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