



**Strengthening  
Supply Side  
Components of the  
Safe Motherhood  
Programme**



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*Newborn baby at Tudun Wada PHC facility, Kaduna*

## Strengthening Supply Side Components of the Safe Motherhood Programme

### Summary

Strengthening safe motherhood services was a key initiative in all PATHS-supported states and at Federal level. Nigeria has one of the highest maternal mortality ratios in the world and addressing this was seen as a priority by all stakeholders. Support was given to both the supply- and demand-side components of safe motherhood (SM).

Supply-side activities focused on improving maternal health care service delivery, by improving quality of care and access to skilled attendance at birth

and particularly Emergency Obstetric Care (EOC). Particular interventions included:

- Strengthening EOC in selected public and private health facilities by training of health care providers, provision of equipment, and minor refurbishment of health facilities.
- Building State Safe Motherhood Committees (SSMCs) to play a stewardship role of the state Safe Motherhood programme.

Through this support more EOC centres were established and equipped and staff were trained to provide EOC services. Results showed an increased utilisation of services. In addition, educating TBAs on responding to danger signs and establishing TBA alliances was a key initiative in Enugu State.

At the Federal level the Integrated Maternal, Newborn and Child Health (IMNCH) strategy document was developed to focus on the need for a continuum of care for the mother and child. IMNCH is a new approach, is evidence-based and is consistent with the World Health Assembly Resolution WHA 58.31, which urges member states to among other things accelerate actions to ensure universal coverage of maternal, newborn and child health interventions. To ensure synergy in government efforts to meet the health needs of Nigeria, the IMNCH strategy was harmonised with the Ward Minimum Healthcare Package (WMHCP).

### *Health talk to pregnant women at facility, Kaduna*



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# Introduction



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## *Mother and Child, Enugu*

Reducing maternal mortality and increasing skilled attendance at birth are the two main targets of the fifth Millennium Development Goal (MDG), which aims to improve maternal health. Nigeria has one of the highest Maternal Mortality Ratios (MMR) in the world. The World Health Organisation (WHO) recently estimated that Nigeria's MMR was 1,100 maternal deaths per 100,000 live births.<sup>1</sup> The National Road Map for Accelerating Attainment of the MDGs Related to Maternal and Newborn Health in Nigeria reported a MMR of 800 per 100,000 live births.<sup>2</sup> Maternal mortality in the North of the country was reportedly higher than in the South and a study in Kano state found a MMR of 2,240.<sup>3</sup> A Nigerian woman's life time chance of dying in pregnancy or childbirth was 1/18 and despite having only two percent of the world's population, Nigeria contributed 10 percent of the world's maternal deaths.

- 1 Hill K, Thomas K, AbouZahr C, Walker N, Say L. Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. *Lancet* 2007; 370: 1311-1319.
- 2 Federal MoH. Road Map for Accelerating the Attainment of the Millennium Development Goals Relating to Maternal and Newborn Health in Nigeria.
- 3 Adamu YM, Salihu HM, Sathiakumar N, Alexander GR. Maternal mortality in Northern Nigeria: a population-based study. *Eur J Obstet Gynecol Rep Biol* 2003; 109: 153-159.

For the reduction of maternal mortality it is important that women have access to skilled care during child birth. However, approximately 66 percent of Nigerian women delivered outside health facilities without skilled attendance.<sup>4</sup> For women with a life-threatening obstetric complication, it is crucial that they have prompt access to health facilities which provided Emergency Obstetric Care (EOC). Inability or delay in reaching such facilities might lead to the death of the mother and her unborn or newborn child. Delay in accessing EOC has three levels.<sup>5</sup>

1. Delay in recognising the problem and its severity and in deciding to seek professional care.
2. Delay in reaching a facility which can provide EOC.
3. Delay in receiving life saving treatment once at the EOC facility.

In the PATHS states demand-side interventions for safe motherhood addressed the first and second delays and supply-side interventions addressed the third delay. The supply-side component aimed to improve maternal health care service delivery, by improving quality of care and access to skilled attendance at birth and particularly Emergency Obstetric Care (EOC). The demand-side component<sup>6</sup> aimed to sensitise and mobilise communities, creating awareness of and support for safe motherhood and increasing access and demand for maternal health care services, including emergency transport and loan schemes at community level. This technical brief focuses on the supply-side component.

Functional health systems are important for maternal health and must ensure that referral systems for transportation of emergency obstetric cases are operational between health facilities; and that skilled health workers, drugs, equipment and other medical supplies are available when needed to save a mother's life. However, Nigeria faced great challenges - a WHO study in 2000 ranked the performance of Nigeria's health systems 187 out of 191 countries.<sup>7</sup>

- 4 National Population Commission, ORC Macro, USAID. Nigeria Demographic and Health survey 2003.
- 5 Thaddeus S, Maine D. Too far to walk: maternal mortality in context. *Soc Sci Med* 1994; 38 (8): 1091-1110.
- 6 For more details on the demand-side component, see the PATHS Technical Brief on Increasing Access to Safe Motherhood Services.
- 7 WHO. World Health Report 2000. Health systems: improving performance. WHO, Geneva, 2000.

# The Response

## Strategies to address the challenges

The strategies adopted by all PATHS-supported states included:

- Supporting State Ministries of Health (SMoH) and State Ministries of Local Government (SMoLG) to strengthen EOC in selected health facilities by training of health care providers, provision of equipment, and minor refurbishment of health facilities.
- Recognising that a significant percentage of deliveries take place outside the public arena, training and equipping private/faith based sectors and working with traditional birth attendants in recognition of danger signs.
- Supporting SMoH, SMoLG and other related Ministries such as the Ministry of Women's Affairs to address low awareness and demand for maternal health services at community level by raising awareness on danger signs of pregnancy complications and mobilising communities for birth and emergency preparedness. In some states this involved support for the development of community emergency transport and loan schemes and support for the establishment of blood donor groups.
- Facilitating the establishment and capacity building of State Safe Motherhood Committees (SSMCs) or other co-ordinating bodies to play a stewardship role in relation to the development, planning, guiding implementation, and monitoring and evaluation (M&E) of the state safe motherhood programme, including both supply- and demand-side aspects.
- Support to the Federal Government to be better prepared to execute their stewardship role.

The extent to which these approaches were utilised reflected the peculiar challenges to safe motherhood in the different states. The decision to work on safe motherhood demand-side issues in a comprehensive and systematic way in Kano and Jigawa states also reflected stakeholders' concerns about the extremely high maternal mortality ratios in the northern states.

## Methodology and Process

At the inception of the Safe Motherhood programme in the various states, scoping missions were commissioned to identify and inform areas of possible support to safe motherhood. All states agreed on the basic principles of reducing maternal mortality – namely increasing demand, improving service delivery and strengthening health systems.<sup>8</sup> Shortcomings and gaps identified by the various scoping missions formed the basis of technical and financial assistance to stakeholders to reduce delays for women in accessing essential obstetric care.

There were very few (if any) previous studies of maternal health services in the public and private/ NGO sectors, and reliable data on the extent and quality of provision was lacking. The local evidence base on safe motherhood issues was almost non-existent. Findings<sup>9</sup> from the various scoping missions included:

- Health facility infrastructure was mostly in a poor state of repair, and basic equipment and supplies were lacking
- Both secondary and primary health facilities suffered from a lack of suitably qualified staff at all levels and staff were de-motivated and lacked incentives
- Utilisation of public maternal health services was low
- There was generally a poor referral system with no effective means of communication between facilities
- There were no clearly targeted strategies to increase women's access to and utilisation of those services and to eventually make them community owned, community driven and community operated
- There were no definite regulatory/strategic framework documents that focused on safe motherhood

In addition to the above, the health sector as a whole was generally severely underfunded.

8 DUBY F. Report of Safe Motherhood round table meeting. PATHS, Abuja, 2004.

9 For more details see the references 1-5 at the end of the report.

Building upon the National Economic Empowerment and Development Strategy<sup>10</sup>, the National Reproductive Health Policy and Strategy<sup>11</sup> as well as the State Economic Empowerment and Development Strategies<sup>12</sup>, PATHS partnered with states to develop several safe motherhood-related policy papers, strategies, and frameworks. By building on what already existed, incorporating a strong health systems perspective, promoting the need for safe motherhood partnerships with key players outside government, and emphasising the need for an evidence base for successful interventions, this support was crucial to provide guidance and focus to the states.

SM supply-side interventions were based on the widely recognised EOC and Skilled Birth Attendance strategies, which are crucial for the reduction of maternal mortality and morbidity.<sup>13</sup> Two levels of EOC are differentiated, Basic Emergency Obstetric Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC). It is recommended that for a population of 500,000 at least one CEOC and four BEOC facilities should be available to ensure access to EOC.

To reduce maternal mortality it is important that women have access to skilled attendance during labour and child-birth. A skilled attendant is defined as an accredited health professional (such as a doctor, midwife, nurse) who has been trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in identification, management and referral of complications in women and newborns.<sup>14</sup>

In the PATHS states safe motherhood supply-side interventions therefore included:

- identification, rehabilitation and equipping of EOC facilities
- establishment of Life Saving Skills (LSS) training centres

10 NEEDS secretariat, National Planning Commission. Nigeria National Economic Empowerment and Development Strategy (NEEDS), National Planning Commission, Abuja, 2004.

11 Nigeria Federal MoH. National Reproductive Health Policy & Strategy: to achieve quality reproductive and sexual health. FMoH, Abuja, 2001.

12 For example, Kano State Economic Empowerment and Development Strategy (K-SEEDS) policy framework. Kano, 2004.

13 See references 6 to 9

14 WHO. Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM, FIGO. WHO, Geneva, 2004.



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*ANC – Pregnant Woman having Blood Pressure taken, Ekiti*



## KEY FACTS

### *Signal Functions of Functional EOC Facilities*

#### **BEOC**

- Parenteral antibiotics to treat sepsis.
- Parenteral oxytocics to treat haemorrhage.
- Parenteral anti-convulsants to treat (pre-) eclampsia
- Manual removal of a retained placenta
- Removal of retained products of conception by manual vacuum aspiration (MVA)
- Assisted vaginal delivery (vacuum extraction, forceps)

#### **CEOC**

- All 6 BEOC functions, plus:
- Obstetric surgery (e.g. Caesarean section)
- Blood transfusion

- training of various cadres of health care workers in LSS for EOC
- orientation of TBAs in the recognition of danger signs to promote early referral
- establishment of quality assurance systems such as development and use of clinical protocols and maternal death audits
- implementation of a facility appraisal process, targeted support for systems strengthening, introduction of supportive supervision process, and in some states introduction of a quality recognition process
- advocacy on human resource issues in the focal states, to address issues of inequity in the distribution and shortage of skilled attendants



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### *Maternity Ward, Jigawa*

Safe motherhood related structures and committees were strengthened through capacity building; and stakeholders' capacity for facility programme-based budgeting was also strengthened.

Barriers to accessing health care, whether routine care or emergency care, remained a major challenge. Various policies were developed and implemented by State Ministries of Health with the intention of improving access to health care.

### *Examples of initiatives to increase access to care*

1. The deferral and exemption scheme for the very poor and provision of free EOC services, in Jigawa state.
2. The pilot PPP EOC plus scheme in Enugu Metropolitan District provided subsidised emergency obstetric care for poor women. Any poor pregnant woman referred to one of three faith-based CEOC facilities paid 25 percent of the cost of services in the referral facility herself and had 75 percent offset under the scheme (the pilot was supported by PATHS, but this was taken over by the SMoH in 2008).
3. The deferral and exemption scheme linked to the Drug Revolving Funds in Ekiti state.
4. In both Jigawa and Kano states emergency safe motherhood loan schemes and emergency transport schemes were established in over 200 communities.
5. Free maternal and under-five health care programmes were planned or being implemented in Kano, Enugu, and Kaduna.

For more details on these initiatives see PATHS Technical Briefs on Increasing Access to Safe Motherhood Services, Safety Nets for the Poor and Equitable Health Care Financing and A Pilot PPP Scheme in Enugu – Emergency Obstetric Care Plus.

# Results

Key indicators for measurement of the impact of safe motherhood programmes on progress towards the achievement of the MDG 5 are the maternal mortality ratio and the percentage of births that are assisted by a skilled attendant. All the focal states lacked data to assess this impact on maternal health. Internationally there is recognition that maternal mortality is very difficult to measure and, therefore, process indicators are increasingly used for monitoring and evaluation purposes. These include

indicators for the availability, accessibility, utilisation and quality of EOC (including skill birth attendant deliveries).<sup>15</sup>

The safe motherhood interventions were successful in increasing the number of functional EOC facilities, although at state level the overall coverage of EOC remained below the recommended one CEOC and four BEOC facilities per 500,000 people.

Making EOC units functional was achieved through training of health care providers to ensure they had the necessary skills to provide EOC; and through provision of medical equipment, necessary for the health facilities to offer EOC. However, the delay in

<b>Number of PATHS supported EOC facilities and functional EOC facilities per state</b>						
State Population	No of Hospitals supported by PATHS	Minimum recommended CEOC	No of functional CEOC	No of PHC facilities/early bird clinics supported	Minimum recommended BEOC	No of functional BEOC
<b>Benue State</b> 4,219,244	8	8	9	50	34	19
<b>Kano State</b> 9,383,682	10	18	9	20	75	8
<b>Enugu State</b> 3,257,298	12	6	6	56	26	56
<b>Jigawa State</b> 4,372,341	8	8-9	4	19	35	8
<b>Ekiti State</b> 2,384,212	5	4-5	5	20	19	20
<b>Kaduna State</b> 6,006,562	9	12	29	19	48	None functional

The table shows the number of PATHS-supported facilities by state and those that have become functional EOC facilities as at the end of 2007.

CEOC facilities in Benue State included seven Government hospitals and two faith-based hospitals; and in Enugu included four government hospitals and four faith-based hospitals.

In states where PATHS was present for a long period and covered the whole state (e.g. Enugu and ), more progress was made. There was also more progress at hospital level, given the precarious nature of PHC in Nigeria.

<sup>15</sup> WHO, UNICEF, UNFPA. Guidelines for monitoring the availability and use of obstetric services. WHO, Geneva, 1997.

## Equipment donated for EOC facilities



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supply of equipment by the Health Commodities Project (HCP), a sister DfID supported programme, resulted in a significant lag between training of health care providers in LSS and provision of the equipment that was necessary to utilise their skills. This resulted in the inability of supported health facilities to carry out EOC functions.<sup>16</sup>

At federal level, the FMoH was supported through workshops and roundtable meetings to develop a training curriculum for LSS-EOC training for various cadres of medical staff. This resulted in the publishing and subsequent dissemination of various training manuals (a LSS manual for nurses and midwives with Participant's Handbook and Facilitator's Guide, an extended LSS (ELSS) manual for doctors and a modified LSS manual (MLSS) for

Community Health Extension Workers (CHEWs); as well as service protocols (e.g. for reproductive health and family planning) for use by trainers and trainees.

At state level, LSS training centres were established or upgraded, a training of trainers was carried out, and substantial numbers of health workers were trained in LSS-EOC. This initiative was supported by PATHS and other development partners in the states such as UNICEF and the Health Systems Development Project (HSDP) II.

"My skills on caesarean section have improved. Now we have also introduced clinical protocols in the labour room".

*Dr. Garba Baba Nasiru, General Hospital, Wudil.*

### Numbers of health workers trained in the different states

	Master trainers	Doctors - ELSS	Midwives – LSS	CHEWs – MLSS
<b>Benue state</b>	10 LSS trainers	50	420	
<b>Kano state</b>	10 LSS trainers	42	57	36
<b>Enugu state</b>	6 ELSS trainers 16 LSS/MLSS trainers	32	178	171
<b>Jigawa state</b>	No data	25	109	73
<b>Ekiti state</b>	No data	36	45	38
<b>Kaduna state</b>	14 LSS trainers	15	94	40

<sup>16</sup> For more details see references 10 to 12.



### LSS Training, Jigawa

While significant numbers of staff were trained, it was not possible to calculate what proportion of staff were trained since data on state staff strength (public, private and mission) was not readily available. However, as of mid-2008 many more staff still need to be trained and others needed to be employed/deployed and retained.

In addition to LSS-EOC training, other safe motherhood-related courses and workshops for health workers were supported. These varied in the different states according to local priorities.

In all states there were reports that improved capacity to provide EOC in combination with activities that focused on increasing women's access to these services resulted in increased utilisation of EOC facilities. However, poor data availability and quality meant that information that would verify the increased utilisation of EOC facilities was not readily available in all states.<sup>17</sup> Innovative efforts were developed in some states to overcome this problem of non-availability of data.

<sup>17</sup> Heuberger J, Anyebe W, Ijadunola K, Yahya M. Multi state progress review of PATHS' Safe Motherhood initiatives. PATHS, Abuja, 2007.

### Examples of other safe motherhood-related capacity building activities

In Jigawa and Kano states, post abortion care services were supported through the training of doctors and midwives in manual vacuum aspiration (MVA).

In Ekiti state, midwives, doctors and CHEWs were trained on the use of the partograph, which is an important tool for the monitoring and management of women in labour.

In several states, training of health workers in focused antenatal care and intermittent presumptive treatment of malaria.

In Jigawa, a Vesico-Vaginal Fistula (VVF) centre was established; service providers were trained in VVF repair; and rehabilitation of 136 patients with VVF occurred.\*

In Enugu TBAs were orientated on dangers signs to promote more rapid referral and a TBA Alliance was established within one District to promote more transparent practise and collect more rigorous data on deliveries and maternal deaths.

In Kaduna, staff were trained on the use of obstetric case notes to improve ANC, delivery and PN care. Community Health Volunteers were also trained on how to get health information on care of newborn etc.

\* This was an important initiative since Nigeria is estimated to carry 40 percent of the global burden of VVF. This translates into 800,000 cases, many of which occur in the northern states where early marriage and childbirth are the norm.

In its efforts to strengthen health systems, PATHS also supported the establishment of Drug Revolving Funds (DRFs) in the focal states. These helped ensure that essential life-saving drugs for safe motherhood were available in EOC facilities. It was also important that emergency drugs were immediately available in the health facilities where and when they are needed. In Jigawa, emergency cupboards with such drugs were provided in all supported EOC facilities.

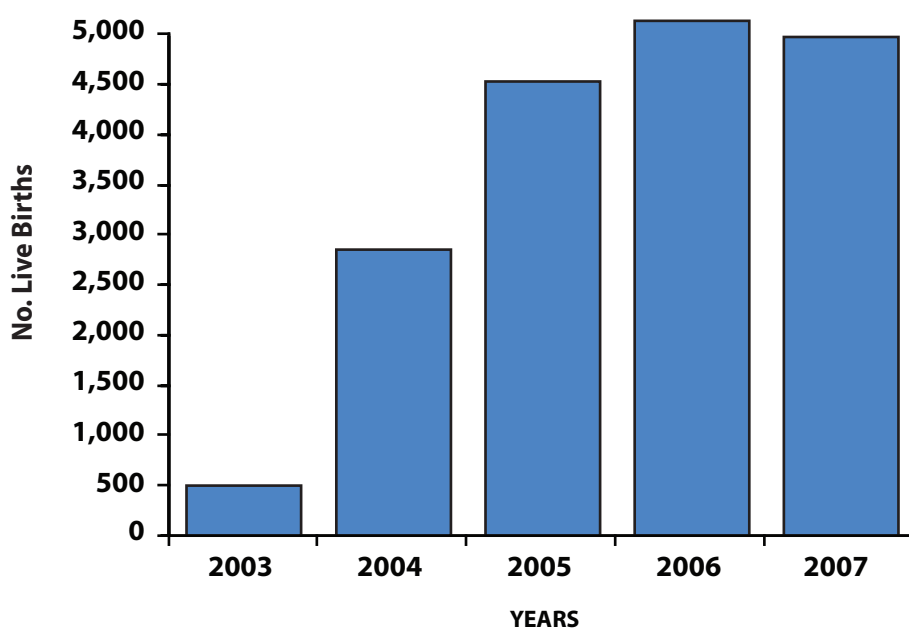
The following graphs show increased utilisation of public health facilities for delivery in Jigawa, Kaduna and Enugu, and for ANC in Kaduna over the period 2003 to 2007. In Jigawa the number of caesarean sections almost doubled over the same period.

## CASE STUDY:

### *Improving Data Collection in Kano State*

The Kano SSMC created a M&E sub-committee, which included a representative from the HMIS unit in the SMoH. Its members made regular supervisory visits to focal health facilities and used a special form to collect relevant safe motherhood data. Members of the sub-committee were trained in data collection and analysis and report writing. In order to improve data recording, standardised maternity registers were provided to all supported health facilities and this resulted in improved record keeping at, and data collection from, the 10 PATHS-supported hospitals. Collaboration between the SSMC and the HMIS unit resulted in the incorporation of process indicators for EOC in the state HMIS. The HMIS and its data collection and reporting tools could be further improved to capture information on obstetric complications treated at BEOC and CEOC facilities.

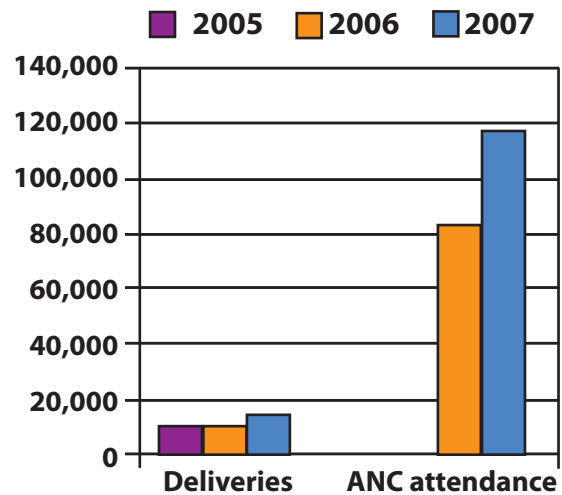
**Total Deliveries in Enugu Public Facilities, 2003 - 2007**



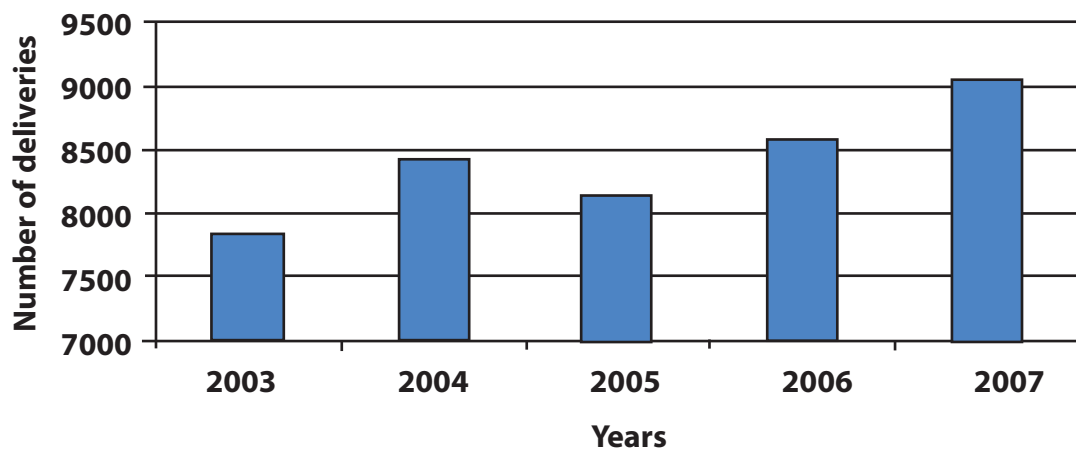
*2007 Data provisional (Oct - Dec outstanding for Awgu and Nsukka DHBs)*

**Graph showing the Total ANC Attendance and Deliveries (2005 – 2007) in all Public Hospitals in Kaduna State**

There is a nearly 50 percent increase in ANC attendance from 2006 to 2007 (during this period, the free MCH policy was being implemented). The increase in deliveries was not as marked.

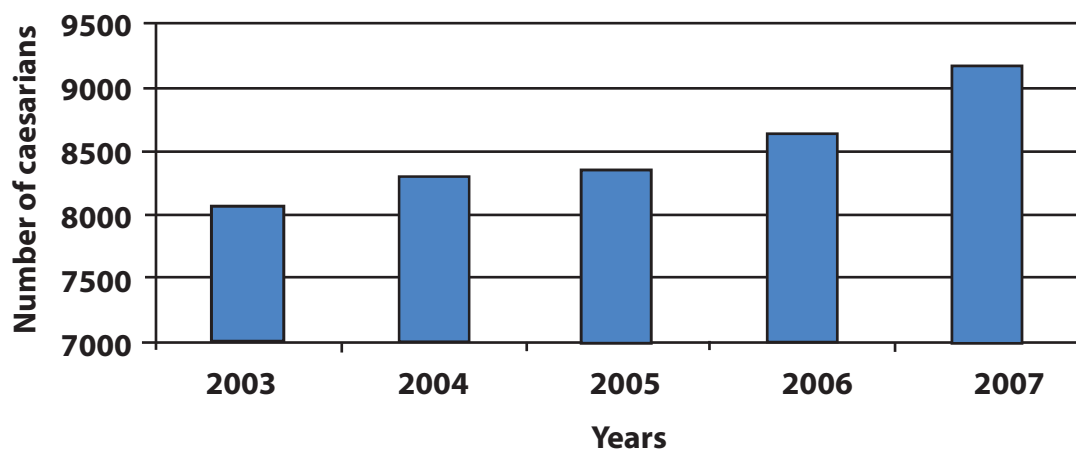


**Number of Deliveries at 11 EOC centres in Jigawa State 2003-2007**



Jigawa showed a steady increase in deliveries. Note: The drop in deliveries in 2005 occurred during rehabilitation work at some of the EOC centres.

**Number of Caecarian Sections Conducted at 8 CEOC facilities in Jigawa State 2003-2007**



# Sustainability

The provision of technical support to the State Safe Motherhood Committees resulted in the preparation of operational plans and budgets for the state safe motherhood programmes. These contributed to the overall plans and budgets of the SMoH and thus increased the likelihood of sustainability of the safe motherhood programmes. It was also important to ensure that annual work plans and budgets for the safe motherhood programmes were prepared in time so that they could be incorporated into the overall budgets of the SMoH and SMoLG. Even where this was done, the weakness of, and lack of accountability within, the overall budgeting process meant that there was no guarantee that funds would be released for planned activities.

Nevertheless, some of the PATHS states managed to buck this trend. Since 2007, Kaduna State government has provided 70-75 million Naira (£280,000) monthly to finance the implementation of the free MCH services policy. Also in Jigawa the Ministry allocated and released N3.6 million (£14,400) of its budget to safe motherhood in 2007, and the Government released N10 million (£40,000) to support free emergency obstetric care. In Enugu, PATHS supported the funding of the PPP EOC pilot to the end of 2007 when the Enugu State Government took over responsibility as part of their wider Free MCH policy with effect from 1<sup>st</sup> January 2008. N164 million (£656,000) has been budgeted for free MCH services of which N41 million (£164,000) has been released for the first quarter of 2008.

Master trainers were trained and various LSS training centres were established in the focal states to ensure sustainability of human resource development for Safe Motherhood in the states. The SMoH must in future ensure adequate funding in their annual health budgets for these training centres, including running the courses. Establishing LSS-EOC training sites in existing training institutions increased the likelihood of sustainability of LSS-EOC training. For example, a fruitful collaboration between the LSS training centre and the Ekiti School of Midwifery meant that equipment required for LSS training was provided by the school. Similarly in Kano state, the ELSS training was conducted at the Aminu Kano University Teaching Hospital.



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*Sign advertising Safe Motherhood Services, Ekiti*

Training health care providers in LSS-EOC was costly. The scaling up of training activities beyond the PATHS-supported health facilities proved to be a great challenge for the SMoH. It was also important to incorporate LSS-EOC training in the pre-service training curricula for health workers.

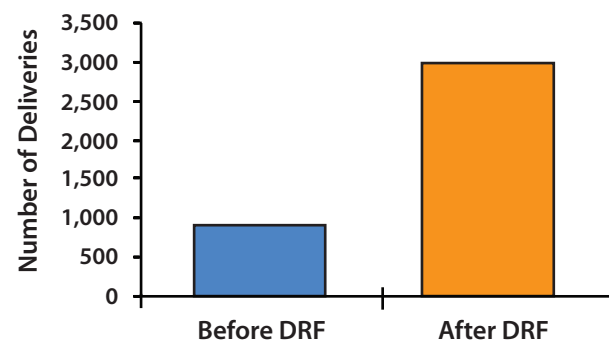
Management systems for equipment and supplies, including maintenance systems needed to be strengthened to maintain the EOC and other vital equipment supplied to the health facilities. Apart from the planned preventative maintenance project in Enugu, this was not a key focus of the systems strengthening work in other states.

Pairing up international consultants with national consultants in giving technical support to the state safe motherhood programmes helped develop in-country capacity to support the work. From a relatively early stage, PATHS switched to a model where national consultants provided most of the in-country technical assistance, with backstopping support provided as required by international consultants.

# Lessons Learned

1. Strengthening SMOH's stewardship role resulted in the formulation of state safe motherhood policies, strategies and operational plans and budgets, which then fed into the overall plans and budgets of the SMOH. This was important to ensure that resources were allocated to the safe motherhood programmes.
2. However, there was less success in getting safe motherhood activities included in the plans and budgets of the SMoLG and LGAs, which were responsible for delivery of maternal health care services at PHC level. Strong collaboration was needed between the SSMC, the SMoLG and LGAs to facilitate the implementation of safe motherhood programmes at the PHC level. In some states (e.g. Kano), poor collaboration resulted in slow progress in upgrading PHC centres to functional BEOC facilities.
3. Where demand creation activities overtake supply-side improvements there is a danger that clients' experiences of poor quality services will undermine demand creation efforts, and result in low morale among health providers. Poor co-ordination between demand- and supply-side activities was initially a problem in several states. This was partly due to the fact that inter-departmental and inter-ministerial working was uncommon and new ways of 'doing business' had to be absorbed. If State Co-ordinating Committees for Safe Motherhood meet regularly, there is less danger of poor sequencing. High-level political commitment to safe motherhood within a state creates a strong incentive for these committees to meet. On a more practical level, simple tools such as checklists that can be used to assess whether CEOC and BEOC facilities are 'fit for purpose' are essential, since they can act as a trigger for intensification of demand creation activity.
4. A health systems approach contributed to the improvement of maternal health and health care in the PATHS-supported states. The strengthening of other systems (e.g. HMIS, laboratory services and DRFs) had a positive impact on maternal health. For example, prioritising EOC facilities for the establishment of DRFs increased the availability of life-saving drugs for EOC.

## Deliveries in PHC Clinics in Benue



5. Increasing access to skilled attendance at birth in rural areas was constrained by the shortage of (female) skilled birth attendants, particularly in states in the north of Nigeria, where many PHC centres and potential BEOC facilities were staffed by male CHEWs. Apart from advocacy, this human resource problem was not adequately addressed by the safe motherhood programmes. Even though CHEWs offered a practical and affordable solution, offering them a modified LSS-EOC was only an intermediate solution, as they were not considered (in the WHO definition) as professional skilled birth attendants. States needed to develop human resource development policies and strategic plans to increase the availability of doctors and particularly midwives in rural areas, prioritising EOC facilities.

# Recommendations

1. There was a need to get the SMoLG and LGAs more involved and committed to the safe motherhood work, since the local government ministry or LGAs were responsible for PHC facilities selected as BEOC facilities.
2. Supply-side safe motherhood activities should not only focus solely on public health facilities, but should also include private and faith-based facilities and TBAs. In Enugu, it was observed that although capacity building, equipping and stocking of facilities mainly focused initially on public health facilities, private facilities remained the preferred place for many consumers. Attention therefore later shifted to the faith-based facilities and TBAs.
3. Improved co-ordination of the inputs and activities of the different stakeholders (including development partners) would ensure the best use of available funds. This could be achieved via a Sector Wide Approach.
4. Since haemorrhage was the leading cause of maternal mortality in Nigeria<sup>18</sup> the establishment of blood transfusion services with functional blood banks for storage of blood for emergencies at CEOC hospitals was crucial for the reduction of maternal mortality. Although in the two northern states of Jigawa and Kano some promising work was done to establish blood donor groups at community level, support for supply-side improvements in this area did not happen. Many hospitals lacked refrigerators for storage of blood for emergencies and depended on ad hoc donation of blood by relatives. In future, more attention should be paid to strengthening blood transfusion services. This will involve providing refrigerators for storage of blood, ensuring the availability of reagents and laboratory equipment for screening of blood for transmittable infective agents and for blood-grouping and cross-matching, and greater emphasis on the organisation of voluntary blood donation.
5. Besides the numbers and mix of skilled staff, other human resource problems which were addressed included the negative attitudes and woman-unfriendly behaviour of health care providers. Training initiatives in interpersonal communication and counselling to promote client-friendly behaviour have improved interaction between clients and providers. Training was reviewed in Jigawa for example and the response was very good. IPCC training needs to continue.
6. Little attention was paid to strengthening of referral systems between health facilities by improving transport and communication, notably for referral of emergency obstetric cases from PHC and BEOC facilities to a CEOC hospital. Effective referral systems are important to ensure that women with life-threatening obstetric complications have timely access to EOC.

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<sup>18</sup> Campbell OMR, Graham WJ. Strategies for reducing maternal mortality: getting on with what works. *Lancet* 2006; 368: 1284-1299.

# Conclusion

Significant strides were made in strengthening some of the key components of supply-side safe motherhood services in the PATHS-supported states. This included consensus on key interventions for safe motherhood based on international guidelines; nationally agreed training curricula for LSS; testing of approaches to increase access; expansion of functional service delivery points; increased allocation of funds for safe motherhood; systems strengthening; and increases in utilisation. However, a great deal remains to be done to broaden the initiative and to ensure sustainability. The support of a wider range of development partners and other donors will be required as will increased state capacity to leverage additional funds from internal sources (e.g. such as through the Federal MDG fund).

## *Outreach Services at Sakwaya Community, Jigawa*



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