THEY WILL LIVE IF WE DO NOT LEAVE THEM

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EBONYI STATE UNIVERSITY
ABAKALIKI

THE EBONYI STATE UNIVERSITY 11TH INAUGURAL LECTURE

TOPIC:

THEY WILL LIVE IF WE DO NOT LEAVE THEM

– AN INTERCEPT BETWEEN MATERNAL MORTALITY AND ETHICS

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Nigeria.

MAY, 2018

Ebonyi State University

THE 11TH INAUGURAL LECTURE

"THEY WILL LIVE IF WE DO NOT LEAVE THEM" - An Intercept Between Maternal Mortality and Ethics

BY

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31ST May, 2018

ISBN –

First published 2018

Printed by
Uncle-Chyk Concepts
55 Obioma Street,
Achara Layout Enugu
Nigeria

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DEDICATION

To the sweet memories of my parents and guardian angels Chief & Mrs. E.I.C. Umeora for their sublime role in my life.

To my wife, MaryJoanne my best companion and friend

To my children, my world, my Joy.

To my siblings, Bridget, Emeka, Agha, Tony and Nazom and their spouses.

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PREAMBLE

Story of two Nkechis

Mrs. Nkechi A was a young beautiful elegant lady of 28 years and a close friend. Two years into my residency training in Benin, I received a call, Nkechi had died!! What followed was a poor narrative involving pregnancy, doctor, nurse, Caesarean section, sepsis and she died!! Her baby who never knew her mother is 19 years now.

The Abakpa market is popular here in Abakaliki and attracted my wife and I when we moved in here. We did shop for our grocery and items there amongst other things. Perchance we had a favourite shop which we regularly patronised. This Saturday, we routinely approached the shop only to notice that it was closed and right on the door, was a poster of Mrs. Nkechi B, on top of which was boldly written 'OBITUARY'. My wife was shocked. We had seen the young newly married lady happily pregnant less than two weeks earlier. The narrative once more, pregnancy, doctor, nurse,

childbirth, and she died.

Two more stories

In a private hospital in Lagos, a 38-year-old woman, Mrs. NJ with 9 children alive delivered her 10th and started bleeding. Right in front of the medical officer and medical director, she bled to death with her womb intact. I was the medical officer with limited knowledge. And in a capital city Southeast Nigeria, Mrs. OC was carrying a twin pregnancy and came in with contractions at 34 weeks. The narrative again included doctors, drugs, fluids and she died with her babies.

There are other countless stories. The foundation in all these avoidable disasters was the fact that we FAILED them as individuals, professionals, institutions, communities and society, and they were LEFT TO DIE.

PROTOCOLS (as established).

ACKNOWLEDGMENT

It is with mixed feeling that I stand here to deliver this inaugural lecture which really should be a happy and joyous occasion, but the content of this lecture leaves one no choice but to get back deep in thoughts as to where we got it all wrong.

Before I start I must pay homage to those whom it is due. The significance of this day will not pale in my memory for a long while. Looking back to where I came from, all I owe, is thanks to the Almighty God, my mentors, teachers, peers, colleagues and the University community. That a young man from rural Nigeria, who had some of his primary education in the village setting with some lessons under the Gmelina or mango tree, at this moment mounts the podium in front of a distinguished body of academics to 'usher' in a Professorial career, says much about God's Grace and Providence.

Sadly my dear parents are no more, but I can imagine what their joy could have been watching and listening to their little boy, Ugoo deliver an inaugural before seasoned academics, administrators and managers.

May God continue to rest them in peace.

I dedicate this lecture particularly to my mum. She was an accomplished midwife and ran a private outfit dutifully. She undertook the delivery of many children in the community. I watched her and her practice closely. Her dedication and commitment were unequalled. Many women were delivered of the babies successfully and with joy. Occasionally I saw some transferred to a higher facility, but on no occasion did I see any one leave in a casket. Maternal Mortality Ratio (MMR) was a proven 0/100,000 in a facility without the modern gadgets and even without partograph. It boiled down only to humaneness, humanity, duty and care. She never left them and they lived.

It was Chinua Achebe who wrote ***"Those whose palm kernels were cracked for them by the benevolent spirits must not forget to be humble" Things Fall Apart.***

Surely my palm kernel was cracked for me at every stage by benevolent spirits, hence I must recognise and pay respect to men and women who over the decades have guided and led me to this podium today. My early

education spanned through the cities of Lagos, Aba and Umuomaku and helping me navigate the early waters included Mr. SO Okeke (†), Nwafor (Onyeobialu) (†), Alaeto, Atuenyi, Ogu and Mrs Muonanu among others. May God continue to rest the departed and bless the living.

My unreserved and eternal gratitude goes to Francis Cardinal Arinze, Most Rev. Dr. Albert K Obiefuna(†), Very Rev. Msgr. Okee Patrick Achebeh (†), Very Rev. Msgr/Prof. JB Akam (Chancellor Tansian University), Very Rev. Msgr. Peter Akaenyi, Very Rev. Msgr A. Madubuko and Very Rev. Msgr. Philip Chinyelu (†). Perhaps no others played more significant roles than these men in my upbringing in morality and discipline during my formative years in the seminary where I had my secondary education. Others are: Most Rev Dr. Dennis Isizoh (auxiliary Bishop of Onitsha archdiocese), Very Rev. Prof Hye Ichoku (Health Economics UNN), Rev. Frs. Anazodo, Willie Ekeh, Boniface Ezeoke, Alphonsus Ezeoke, Leo Okoye, Clem Aghadinuno, Clem Ilechukwu (†), Jude Ezeanokwasa, Zeph Uzor, Pantaleon Umechukwu, Stephen Chukwujekwu (who taught me **considerations for others in all things and all times**) among others. In a special way I remember the Late Rev.

Fr. Felix Anoliefo (†) whose humanity and spirituality in the first place attracted me to the seminary. I cannot forget that day in April 1980 when your death was announced in far away Rome. May God rest your soul '*in aeternum'.*

Then followed my University education where I met and was guided by men of academic timbre and calibre. I must mention first, Prof Fidelis Ogah (former VC EBSU), who took the first lecture I had as an undergraduate at UNN (Biology 151A). Top on this list also are Prof PO Okeke, Obasi Igwe, Otagburuagu, Prof Mgbodile, Modie (†), Prof Obikili, Rohatgi, Chude (†) in the preclinical years. In my clinical years, Prof OLV Ekpechi (†) perfect gentleman with impeccable Queen's English, a father, role model, friend and motivator, Professors BC. Ozumba (VC UNN and super motivator), Onuaguluchi (†), ACJ Ezeoke (†), Ikeme, Anezi Okoro, Modebe, Iloeje, Kaine, Attah, Onwubualili, Onwubere, JC Okafor, Aghaji Martin and Ikerionwu.

My training and mentorship continued during my internship under the watches in far away Kaduna (Nigerian Army Reference Hospital) of Generals John Ulasi, MC Ezeoke, JO Ojukwu, Idehen, Brume(†) Sada

and Osho. I remain grateful.

Perhaps my best platform remains my residency training in OBGYN at the University of Benin Teaching Hospital. It was a family and remains so till date. My respect to my foremost mentor and role model Professor Eugene Edonehi Okpere (I will be loyal forever), Prof AAE Orhue, FE Okonofua, AU Oronsaye (†), AE Ehigiegba, Aisien, EP Gharoro, ABA Ande and ME Aziken. These were the men and woman. They impacted knowledge, skills and discipline.

And eventually when I joined EBSU/EBSUTH, I met the best in Prof. Emeka Egwuatu, a father, a clinician, academic, another perfect gentleman always on short sleeves, role model, friend and mentor. I learnt so much running my clinics besides him for some time. Added to that, he taught me firsthand, the art of scientific writing and the rest is history. In the same vein was Dr. Mrs. Eseohe Anezi Okoro. Prof. Mrs. Esther U, Ajuluchuku is worthy of mention here as one who raised my awareness in research ethics. To her credit I did eventually pursue a Masters in Research Ethics. I remain grateful for that push.

My excursion into Ethics led me into the path of some great men and women who I hold in high esteem, Profs Carel Ijsselmuiden, Doug Wassener,Mariana Kruger, Nhanhla Mkhize, Jager, Teresa Rossouw and Schoeman , Others are Carla Pettit, Mrs Schoeman(RIP), (Universities of Pretoria and Kwazulu Natal) and all the faculty members at the South African Research Ethics Training Initiative (SARETI). Also on this list are Prof Nancy Kass, Dr. Adnan Hyder, Alex Morris & Joe Alli (Johns Hopkins, Baltimore). Special thanks and recognition for my friend Prof Felix Chukwuneke who introduced me to SARETI. My friends in ethics, I salute you, Dr. Chi Primus, Sithembile Rusario, Martha Nkrumah, Kelly Masokoemeng, Yakubu Aminu, Derrick Elemu, Tunde Olawale and Kayode Oyedeji.

It is now time to recognise my colleagues and peers who in no small measure contributed to this journey thus far. They are Dr. SO Onuh, Professors GO Igberase, AC Okonkwo, Joe Eigbefoh, Drs Olatunde Onafowokan, Okuns Ohiosimuan, A. Igbafe, Professors SA Okogbenin, PI Okonta, PN Ebeigbe, L Omo-Aghoja, E Ojiyi, M Momoh, OE Ezechi and F Okogbo. Others are Drs. V. Osayande, Osenwekhae, Jude Okohue, Pat Asor, Amayo, Osazuwa, Gerald Ikena, Max Odiegwu, Paul Okubor, I

Igbinovia, Philip Ekpe, Ikeanyi amongst others. Prof. Joe Onakhewor (†) and Dr. Chuks Unegbu (†) I remember you, rest on in the bossom of the Lord.

And right here in Abakaliki are my friends and colleagues who toiled and researched together all the way. Professors Brown Ejikeme, Ulu Ogbonnaya, PC ibekwe, AC Imoh, I Sunday-Adeoye, JN Eze, F. Iyare, PO Ezeonu and Maryann Ibekwe. Others are Drs. CG. Nwigwe, RC Onoh, JA Obuna, COU Esike, BO Anozie, AK Onyebuchi, Chuma Egbuji, Obiorah Asiegbu, I Okafor, J. Agboeze, E, Ndukwe, E. Nwizu, Malachi Ani, EN Ekuma Nkama, F Onu, CA Kalu, AN Anuma, IBO Dimejesi, MI Nwali, JO Egede, C. Mgbeafulu, C. Anikwe, V. Obi, AB Onwe, EE Ede, Esther Emeka-Irem, Uche Nwaedu, Nwabunike Okeke, Emmanuel Onyekelu , Okay Mbanefo, L. Obinna-Igboanuzue, A. Ikeotuonye, Adiele, Mamah and the rest. Rev Dr. Chidi Obasi and Rev. Dr Obuna, you have been an inspiration. So also my family at St. Vincent's Ndubia, from the proprietor Most Rev Dr M.N. Okoro, to the Board chairman and members, Very Rev. Msgrs A Iwueke, P. Muoh and Ajah, Rev. Frs. Isaac Ogba and Vincent Odom as well as Rev Srs, Cecilia Chukwu and Perpetua. May God bless you all now and forever.

In a special way, I remember you, my dear friend Roland Ibekwe. It is still so fresh but rest on in peace.

My friends and family in Abakaliki, I extend my warmest regards, Dr. & Dr. Mrs. Emma Echiegu, Dr. & Mrs. Egbuonu, Dr. & Mrs. Chester Onuora, Dr. & Dr. Mrs. PCI Umoke mni, and all the others numerous to mention. Through the years, I have also met great men in the profession who provided me with ideals to look up to, they motivated me, and they urged me on. There are also friends and colleagues who stood by me and asked after my progress. To you all I say thank you: Professors Nimi Briggs, CT John, AOU Okpani , Drs. R. Ogu & Ngozi Orazulike (Port Harcourt), Archibong, Etuk, Ekabua (Calabar), JIB Adinma, Okay Ikpeze, N. Obiechina, JI Ikechebelu and Obi Nwosu (Nnewi), L Ikeakor (Awka), Feyi-Waboso, Chuks Kamanu, Bala Audu, Bukar (Maiduguri), Yinka Omigbodun, Ilesanmi, Ayo Arowojolu, Sina Oladokun, Chris Aimakhu (Ibadan), Tunji Adeniji (Osogbo), E Orji, B. Loto, U. Onwudiegwu (Ife), Oliver Ezechi (NIMR, Lagos), B. Ekele (Abuja) Uche Nwagha, HU Ezegwui, SN Obi, Frank Ezugwu (Enugu), E Emuveyan, Fabamwo, Dr. Deji Oluwole (Lagos), Yakasai, Sadauki (Kano) Dr. I. Omeje (Kano), Dr. Duum Nwachukwu (Bida), Barth Okorochukwu, Ododo and

Emily Nzeribe (Owerri).

To my medical school classmates who over the years have become family, I remain committed: Professors Maxy Odike, Felix Chukwuneke, Atim Udo, Drs. Ejiofor, Anyadiegwu, Benjamin Mozie, Thaddeus Asogwa, Abraham Chukwu, Emeka Ukaegbe, Tony Agbata, Eziamaka Ezenkwele, Joy Nwufoh, Ikunna Onwuanibe, Chinweike Nwosu, Adaku Nwosu,Thaddeus Agu, Deepak Thomas, Chima Nwaukwa, Tiyo Enechi, John Ojimmah and Nkechi Ekpechi amongst others. God bless you guys real good.

Permit me once more to end this section by paying tributes to those who offered me the platform of EBSUTH and EBSU in 2003. They are Professor Chigozie Ogbu (CMD EBSUTH 2003) and Prof COO Chukwu (CMAC EBSUTH 2003) and of course Prof Fidelis Ogah (VC EBSU 2003). I reserve an unalloyed gratitude to the entire management of EBSU past and present. Without these three definitely, today would not have been. In addition I salute the management of the Federal Teaching Hospital led by the Chief Medical Director, Dr. Ogah Emeka Onwe, the Chairman, Medical Advisory Committee Dr. Robinson C. Onoh and the directors of

Administration and finance – Messrs Chris Ogbu and SN Ugamah respectively. May God continue to give you wisdom to be of service to our mothers.

To the current University administration led by the same Professor Chigozie Ogbu as Vice chancellor, I say thank you for providing this unique opportunity and grand stage to me. Others are the DVC Academics: Prof M U Awoke, DVC Administration: Engr Prof E O Ekuma Nkama and our amiable Registrar: Mrs Bibian Nwokwu. May God bless you all.

Finally, getting to this stage was rough. My application for this promotion came in the year 2009 following the advice of my mentors consequent upon the volume of my creative academic output. The faculty approved of this application and thus the journey started till the official announcement by the end of 2014 (five years), though backdated to 2012 without further benefits. It was a journey that involved multiple internal and countless external assessments and shifting criteria at any stage. I thank God and the University hierarchy and committees that it all ended at some point. However, I have a prayer, that no further hardworking academic be put through this route of psychological and mental

stress and drainage. It has negative impact on the system more than we can imagine. It is an ethical obligation that we follow due processes and timely too. Our sister universities are at that stage. We can get there now.

INTRODUCTION/THE TOPIC

It was the inaugural lecture of one of my teachers and mentors Prof Austine Oronsaye (†) delivered at the main auditorium of the University of Benin, Benin city Edo State about the year 2000 that got me thinking ever since. The lecture was titled '***That they may live and enjoy the fruits of their labour'***. The question begging for an answer since then has been 'Why should they not live and really enjoy the fruits for which they have laboured? We are talking about labour that emanated from Divine injunction for the propagation of the human race. They did not bring this labour unto themselves but was entrusted unto them by God, and permit me to say 'perpetuated' by men. These thoughts never left my mind and this lecture will attempt to provide answers to this question.

Then there came this fateful morning, Dr. Mrs. AM, then a medical student under my care in her first pregnancy, had come for her prenatal care and everything was going on right. Before she left, she paused and said ***'Chief please do not leave me, be there for my delivery,*** I was taken aback. She had heard I was to proceed on my annual leave just before her due date. I reassured her

that even in my absence, my team will function optimally and do the needful for a satisfactory outcome. She agreed but insisted and said '***Sir, I do not want to suffer maternal mortality'***, and I was like, 'What'? She continued ***'My mother died during my birth'***. I was silent for a while, and then reassured her, ***'I will not leave you'***. I spent about $400USD to reschedule my flights with Delta Airline. I stayed with her and the outcomes (mother and child) were satisfactory. Mrs. AM is alive today, her life is worth more than $400USD and the joy I derived by being around her in labour and delivery also could not have been bought with $400USD. And from that encounter, this topic took shape – **THEY WILL LIVE IF WE DO NOT LEAVE THEM.**

This topic speaks to maternal mortality in our society - the death of a woman in pregnancy or pregnancy and/or childbirth related events. Sadly, this is endemic in our society but craftily ignored by all of us or rather we choose to believe that we are not involved. Believe it or not, the death of any woman in our society directly or indirectly impacts on each and every one of us. When a woman dies, a man becomes a widower, a child or children become(s) motherless, a family loses a curator/provider, the society loses a member and

probably a generation is terminated. Our society is rife with unadulterated crime of various guises today and Psychologists as well as criminologists will point to data and tell you that most of the perpetrators have an unbalanced family background. Maternal mortality dislocates family balance, robs children of their primary educator, formator, guide and counsellor. The effect may be upon all of us.

THE MAGNITUDE OF THE PROBLEM

Publications in the print and electronic media, scientific journals, and conference and seminar presentations are rife with figures on maternal deaths in the world and Nigeria. In spite of all these, understanding the magnitude of this scourge seems difficult in our clime. We see and note the figures, but seemingly never come to their full realisation and appreciation. I have tried so much to resist the temptation to replicate those figures here (we may encounter them later in this lecture). At this point, such figures may mask the real faces, facts, and family anguish and tears behind those figures. Meanwhile, the figures may be misleading or may not paint the whole picture nor speak to the scourge in details. Suffice it to say that incidence of maternal

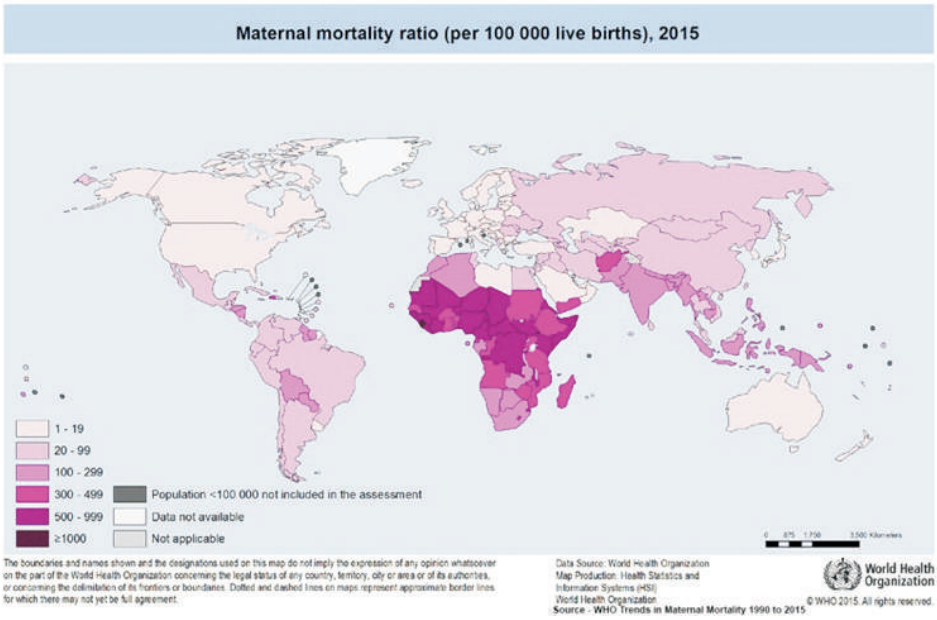
mortality is 100% not just to the individual and her family but also to her community, society and the nation as a whole. For each woman that suffers maternal death, the entire humanity loses. Let us reflect for a moment; think back to a family we know or just try and picture one; a happy family of a newly married couple and by God's special blessings the woman got pregnant. Everyone is excited, preparations kick in for delivery, toys are bought, infant's clothing, bath are bought and brought home, the room is specially painted and cot provided. Everyone is expecting, grandparents, parents, couple, family, and friends even organised baby shower. Then come the D day and D for delivery suddenly turns to D for death. Let us just reflect on the mood for a moment. Multiply this scenario by three or more and situate them in one community within one year. That invokes more of the true magnitude of the scourge. The stories, the emotions, the pains behind these figures are more telling than the figures. Any family that suffers maternal mortality can never be the same again.

However, one must still take a peep at the figures. In a large cross sectional study in the country where data was prospectively collected from 42 out of the 46 federally owned hospitals (Teaching hospitals and

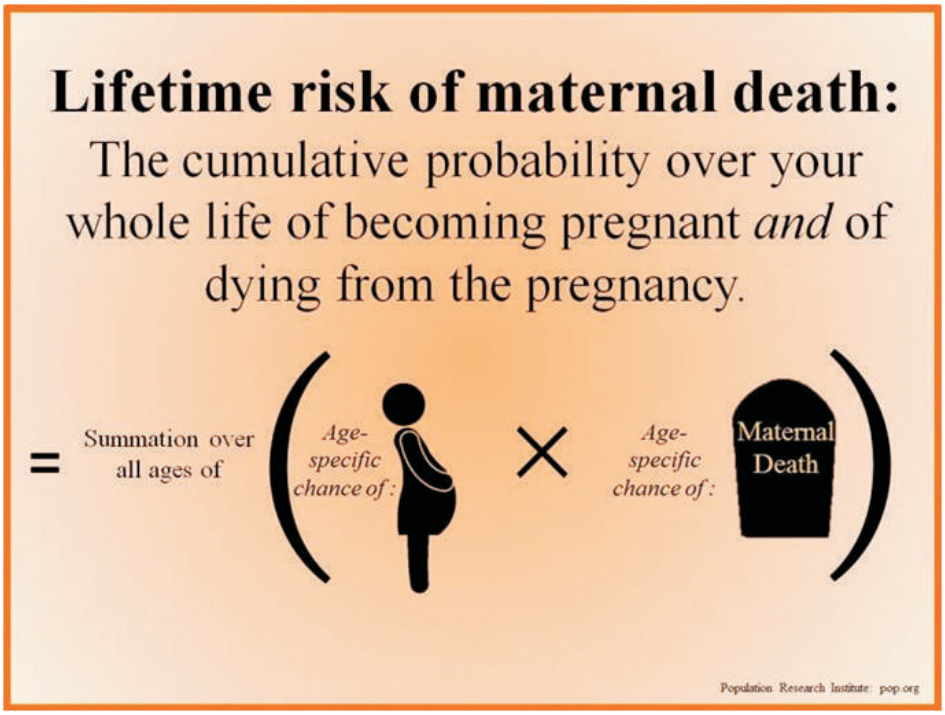
Medical centres) on severe maternal outcomes, 988 women died in a one-year period out of a total of the 91,724 live births during the same period[1]. Statistician would put that as a maternal mortality ratio (MMR) of 1088/100,000 live births. This may not make much sense to us. Nine hundred and eighty-eight women translate to about eight jets with an average capacity of 120 Nigerian passengers, crashing and killing all on board within one calendar year. Imagine that! But that is exactly what happened here in Nigeria between 2013 and 2014, not in the skies but in the labour wards of the best centres we have to offer. So many other figures (some higher, some lower) exist in other sources but are mainly estimates. The ethics of such estimates are questionable. The figure I used above is the most authentic and remember, may even be a gross underestimation since we know that more maternal deaths occur in the communities and peripheral health posts. Most of the victims do not make it to the tertiary institutions and therefore remain undocumented.

I will not bore you with figures. In 2016, the Permanent Secretary of the United Kingdom's Department for International Development, DFID, Mr. Mark Lowcock at a meeting with Vice President Yemi Osinbajo at the presidential villa, Abuja stated that, while Nigeria

constitutes just two percent of the global population, it disproportionately accounts for 10% of global maternal mortality figures[2] Nigeria returns figures worse than Ghana, worse than Togo, worse than Republic of Benin, worse than Niger, worse than Cameroun, worse than Chad (all, our next door neighbours). May be this is not embarrassing to some of us.



The World Bank estimates that a pregnant woman in Nigeria has a 1 in 22 fold risk of dying of or in that pregnancy compared to 1:11,500 and 8,400 in Norway and European Union respectively. The Nigerian figure is higher than the average for sub Saharan Africa (1:36) and low income countries (1:130)[3]. World average is 1 in 180[3].



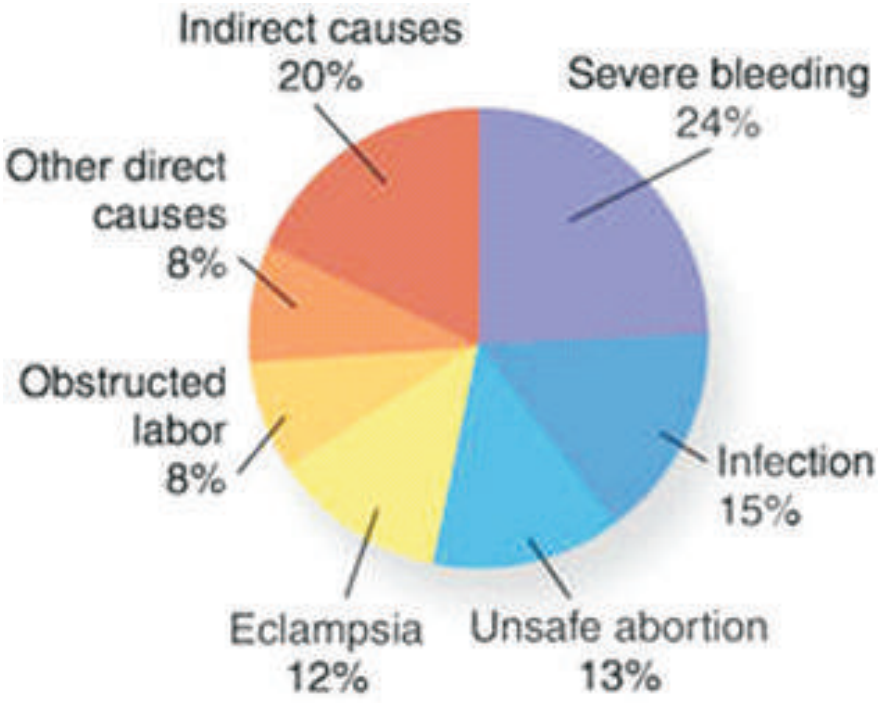
The importance and significance of maternal death make it the most discussed and dominant inaugural lecture topics by Professors in obstetrics and gynaecology over time. That it has continued unabated means we have not done enough, or have been going about it the wrong way. Some pieces are missing and I believe these are the pieces are embedded in ethics.

PECULIARITIES OF MATERNAL DEATHS IN NIGERIA

The causes of maternal mortality have not changed over time and remain almost same globally with changes only seen in their extant contributions. They include severe bleeding or haemorrhage, infections, hypertensive complications

including resultant convulsion in pregnancy, obstructed labour and its sequelae including ruptured uterus (womb) and abortion-related complications. While severe bleeding is the leading cause worldwide underlying approximately a quarter of the deaths, obstructed labour and ruptured uterus contribute majorly in Ebonyi State[4] and earlier it was infection[5].

Key contributors to maternal mortality



As mentioned earlier each of these causes can be found anywhere in the world but the women in such environments do not die at the rate ours do. What is the difference? The response! While the health systems in most countries anticipate and have base preparations to

handle such complications, it cannot in any good conscience be said of the Nigerian Health system which embarrassingly is ranked 187 out of 190 in the world better only than Democratic Republic of Congo, Central Africa Republic and Myanmar[6]. Having a system of preparedness and readiness, delivery and effective response is all rooted in ethics of care and ethics of responsibility and leadership.

Each time the high maternal mortality ratio in Nigeria comes up, fingers are quick to point to the hospitals and health workers as culprits. Unfortunately majority of us fail to realise that whatever happens in the hospital is just the last in a series of mishaps which might have strewn the pathway of the mother from infancy till her demise[7]. This inaugural lecture aims at itemising the different levels of responsibilities and contributions to maternal deaths comprising the individual, family, community, institutions and government. Before we go on to look at the different human/institutional contributors, let us understand some principles of ethics.

ETHICS AND MATERNAL MORTALITY

Ethics is not a set of rules to be implemented in a clinical

setting. Ethics is dynamic, it lays down a moral construction and strikes a conversation on the way things should be done 'rightly'. Unlike in law, where a set of rules rigidly applies, in ethics one needs to think 'outside the box'. Ethics derives from the good conscience and good intentions and pursues good and acceptable outcome. It demands the best intention and outcome in whatever we do and in whatever condition. It describes and demands the 'ought' in any given situation. It means in terms of maternal mortality, 'the ought' that needs to be in place and/or needs to be done to ensure a satisfactory outcome, hence the prevention any maternal death.

Medical practice is rooted in ethics. Ethics seeks to raise one's consciousness to do good. The definition of GOOD in this sense is absolute, the GOOD as exists in the phenomenal realm (if we remember the story of allegory of the cave by Plato)[8]. Ethics encompasses the generally acceptable norm to achieve the good for an individual and/or the society. In reproductive health, it involves all parties playing their roles in a morally acceptable manner to achieve health for the mother and her child. The parties here include all of us as members of the family, institutions and society.

For our discourse here, I will want to highlight three ethical concepts namely, the foundational ethical models (categorical imperatives and Utilitarianism), virtue ethics and care ethics as all of them at one instance or the other come into play on the subject of maternal mortality.

THE FOUNDATIONAL ETHICAL PRINCIPLES

Western ethics have majorly been based on two foundational principles – **deontology and consequentialism.** While deontological principle focuses on what is just and ought to be done in every circumstance and taking each individual as an end, consequentialist ethics of which the Utilitarian principle (greater good for the majority) is prominent, focuses on the beneficial outcome as the reason for morality in any action. These two principles emphasize the universality and impartiality of actions in all circumstances as justifying them to be morally right.

It was the German philosopher Immanuel Kant who popularised the deontological principles[9]. This principle recognised each individual as self-governing, with innate qualities and an end in himself who cannot be

used as a means by any other. The principle therefore prescribes morality as that with a just intent and can be applied universally and impartially to any individual or in any situation. It does not bother about the consequences, as long as the intent was just. This is encapsulated in the principle of categorical imperative"Act only in accordance with that maxim through which you can at the same time, will that it becomes a universal law." In simpler language, 'treat others as you would like to be treated yourself'. Categorical imperatives are moral obligations irrespective of personal desires. They derive from pure reasoning. It does not matter if one wants to be moral or not, the moral law is binding on all of us.

The utilitarian principles on the other hand popularized by Jeremy Betham and John Stuart Mills hold actions justifiable based on their utility (result/consequent). The intent is irrelevant. This is to say in a simpler term, the end justifies the means but this end has to be the attainment of happiness/avoidance of pain by the greater number and for the greater interval of time. Utilitarianism does not breed or condone selfishness, it is other-regarding. As it is succinctly put, 'where morality in under consideration, you are special but not

more special than anybody else'.

VIRTUE ETHICS

The Greek philosopher, Socrates was said to have introduced Virtue ethics, but later on became fully developed by Plato and Aristotle[12-14]

Virtue ethics is normative ethics that lays emphasis on the agent rather than on his action. In other words, morality flows from the character of the person and not just a reflection of his actions. In ordinary parlance, we say good begets good.

A virtue is an enduring quality or character trait in a person. It is not a single good deed or feeling but a quality that gets entrenched in the person out of habitual good deeds or actions. It is a positive characteristic that makes its possessor a good human being. Virtue ethics derives from the ancient Greek philosophy from where three features were prominent namely, arête – virtue/excellence, phronesis – practical wisdom, and eudaimonia – flourishing.

In Virtue ethics therefore, the virtuous individual

applies practical wisdom in situations to yield a flourishing end. Practical wisdom is an acquired attribute that enables one to recognise what needs to be done in any given situation. Unlike theoretical wisdom, practical reason results in action or decision. It involves a "perceptual sensitivity" to what a situation requires. Put differently, it is the practical reasoning that motivates a decision and/or action in any given situation.

How I wish I have the clarity to really explain eudaimonia, it may be a bit tricky but I will try. Eudaimonia can be interpreted as an objective state of 'well-being', 'happiness', 'blessedness', and in relation to virtue ethics, as 'human flourishing'. Aristotle described it as the appropriate goal of human life. It consists of exercising the characteristic human quality -- reason— as the soul's most proper and nourishing activity. In his Nicomachean Ethics, Aristotle, like Plato before him, argued that the pursuit of eudaimonia is an "activity of the soul in accordance with perfect virtue[15] within the community.

The four cardinal virtues according to Plato are, wisdom, justice, fortitude and temperance. Do we as leaders in

our circles, institutions and hospitals possess these qualities and apply them in situations of maternal health care in order to prevent unnecessary death If we are all intrinsically good, all that can come from us is good.

CARE ETHICS

Care ethics is a normative ethical theory, which dictates that moral response is governed on the basis of interrelationship between persons and care for persons. Care ethics makes the person the centre and beneficiary of a just action. Unlike the deontological and consequentialist theories, it moves from 'what is just' to 'how to respond'. Three concepts form the basis of this moral premise as follows: the dependence and interdependence of persons; the understanding that particularly vulnerable persons require particular responses to ameliorate their condition and the necessity to critically evaluate details of a situation in order to promote and protect the specific interests of those involved. This is care ethics, a principle that situates the person within humanity and needing care to attain the good. We as moral agents must respond to people and their specific needs because we are part of

the greater humanity. The elements for effective care ethics include[10]

Attentiveness – to recognize the need of others in order to address them.

Responsibility – the obligation on us to care.

Competence – the capacity to discharge the responsibility consequent upon the need detected.

Responsiveness - refers to the receptiveness of the care receiver to the care. It does not entail reciprocity. Rather, it is another way of understanding the vulnerability and inequality of those in the vulnerable position, as opposed to re-imagining oneself in a similar situation

Since caring is an impulsive and universal human characteristics, Care ethics is free from the indifference and the charge of moral relativism inherent in the deontological and consequentialist ethics principles. The proponents therefore firmly believe that care is at the heart of morality. Within the ethics of care, the caregiver receives the cared-for, freely. But one's response must be in the “problem-solving” mode, taking into consideration the particular circumstances in the relationship to avoid slipping into the abstract, impartial, indifferent reasoning of the deontologist and

the utilitarian theorist. Ultimately, there is a defining imperative to act that is a critical function of what it means to care[11].

Maternal mortality abounds where the actors dump ethics. The different aspects of ethics above connect us to the legal entity termed 'the duty of care'. Though this lecture shies away from the legal aspects of health care delivery, a simple discourse may suffice here. Duty of care refers to the obligation to offer services or carry out actions for the well being of the patient not just because it ought to be done, and it is for good but also because we are legally bound to do that. When a woman presents to the hospital for management, a fiduciary contract is automatically established and this is binding on the hospital and health care providers. Duty of care requires the hospital/doctor to offer the best possible service to the benefit of the patient. The patient becomes the primary focus and her well being the prime objective. This duty implies that the hospital and care providers cannot abandon the patient for reasons of economy, faith, religion, ethnicity, industrial disputes or any other such considerations. Where the hospital/provider cannot offer requested services, duty requires that she be referred to a more appropriate and

suitable care. Duty of care derives from the Kantian deontological principle stated as 'categorical imperative' and requires one to act in such a way that it can become universally applicable and acceptable. This duty of care can be extended to all the actors involved in maternal health and include family members, institutional heads and members alike, as well as the political class. We are called to duty with good conscience (virtue ethics), to provide all within our power, and do all within our limits to promote and protect pregnant women (care ethics and virtue ethics). It is an ethical obligation for any, and all members of the society to protect those whose lot it is to propagate all of us, to propagate the human race (deontological and consequentialist ethics). I must reiterate that maternal mortality abounds in an environment where all have abandoned their ethical obligations.

It will be essential to explore in details our individual contributions to maternal deaths by abandoning our ethical duties/obligations. I want all of us present here to situate ourselves within the context of care ethics and define our responsibilities within the community as it relates to maternal health and death.

CONTRIBUTORS TO MATERNAL MORTALITY

THE INDIVIDUAL WOMAN

She is the victim. How could she have contributed? Some may chorus 'Of course she did contribute to her own demise', hence my poser - Who contributes to one's own death? We note that she is uneducated, poor, lacks awareness of health facilities, has poor health seeking behaviour, lives in the rural area with transport and/or communication difficulties[4,5,16]. She is extraordinarily vulnerable. Earlier in infancy and childhood, she did not feed well and never achieved her growth potential and also did not go to school. As an adolescent she got married out to an older man, her consent not important. And now as a married woman, she has to procreate. She becomes pregnant, has no access to, nor utilises antenatal care[16]. At the end of nine months, she goes around the corner to the next door traditional birth attendant (TBA), spends days there without progress, some die there without documentation[17, 18]. It was the will of God. Lucky ones get to the nearby orthodox care centre, with complications but without money or able relatives. She is neglected and she dies often with the fetus in utero. And yet the woman is to blame!!! In a ten-year (1994-

2003) review of contributors to maternal deaths in rural Ebonyi State, the MMR was 789 for the booked and 2,659/100,000 for the unbooked. Fifty percent of those resulting from obstructed labour and ruptured uterus referred to the orthodox hospitals[17].

One could argue that she is a capable agent by virtue of being an adult or an emancipated minor if married out earlier, and therefore responsible for her actions or inactions. But it is not that simple. What control did she have in not having adequate nutrition in childhood? In not attending schools? In getting married early? In not locating a health centre within her reach? In not being able to pay for registration, medications or surgical interventions in the hospitals? Or even the hospital lacking the requisite items and skills to save her? Where is the care ethics by people around her understanding her peculiar circumstances and her dependence on them for optimal reproductive health care? Where is the categorical obligation to improve upon her agency as an adult, her knowledge and decision making ability? What responsibility have we taken to ensure her safety in pregnancy as part of our ethical obligation under care ethics?

Meanwhile the fundamental questions remain: Why do women get pregnant? And how do they get pregnant? Answer to the first is self-evident – to propagate and maintain the human race, you and I and our descendants. They did not choose this role on their own but was entrusted upon them by Divine Will and they have kept to it. That Divine Will prescribed pain as the only untoward effect of the process and not death[19]. Answer to the second: they get pregnant only through the actions of men. Except for Immaculate Conception, men have perpetrated every pregnancy in history, at times by force or without consent. Without the actions of men, there will be no maternal mortality. Men are ethically liable for any maternal death. What virtues and practical wisdom have men exhibited and how much have they put in to achieving the 'eudaimonia' of human flourishing and propagation of the human race? (Virtue ethics).

THE FAMILY

Ethics is rooted on moral reasoning. It considers what ought to be, to achieve the good. Good in its absolute state. How does a family situate the mother's health in the context of 'good' in the phenomenal realm? What is the cost of a mother's life in a family? Unfortunately for

some families, the woman is expendable. What else can explain the inability of a family to foot medical treatment for five thousand Naira, only to come and pay off without force, the mortuary bill same day to cart off her remains for burial A man rather prefers to maintain his libido rather than donate a pint of blood to save his dying wife[20]. For some men, the woman rather dies than they donate blood[20]. In some families, pregnant women not only suffer intimate partner violence[21] but also are apparently 'held in bondage' that accessing clinics days offers a rare opportunity to get out or obtain support from their husbands[22]. One of the greatest delays subsisting maternal mortality in the tropics is the delay to seek treatment[23]. Often times this delay is occasioned by the absence of the husband at the material time, or his outright refusal to allow her seek management or provide the financial backing to seek treatment.

Even in labour majority of women are left to labour alone without support from their spouses not just for companionship in labour but also to provide necessary logistics/errands[24]. One wishes that a family seminar/workshop were convened to dissect the ethics of family dynamics as it relates to maternal death. What

would be the morality serving intimate partner violence in pregnancy, financial deprivation and abandonment in labour All these contribute directly and indirectly to the eventual maternal death. Care ethics is not meant only for the clinician but also for family members. Understanding the needs of the expectant mother and taking responsibility for them.

We, as family members leave our mothers to die. Family members (in this instance both nuclear and extended) have a responsibility to promote and safeguard the health of their pregnant members. Not only is the male dominance over his wife in reproductive health decision-making supported, some family members also support the husbands in prohibiting the women from accessing prenatal care from orthodox facilities and actively ensure they patronise traditional birth attendants in labour. More so, they maintain and promote some harmful traditional practices within the homes that impact negatively on health and may predispose to obstetric complications and hence maternal mortality. These include, some food taboos entrenched in some families where pregnant women are forbidden from certain food including eggs (to avoid the off spring stealing later in life), they end up anaemic

in pregnancy with predisposition to postpartum haemorrhage, and desire for large family size which also predisposes to grandmultiparity (a risk for severe bleeding also). In some societies, family members perpetuate the tradition of female circumcision in adulthood and 'fattening' preparatory to marriage (rite of passage). While the scars of female genital mutilation may psychologically depress a mother, the physical complications may result in obstructed labour and maternal death. Fattening predisposes to obesity with all its untoward effect in pregnancy and parturition. 'You were not born through operation, so you will not born with operation'. This a common colloquial phrase from many mothers and mothers-in-law in some families as reasons to oppose indicated Caesarean delivery. In some cases these have occasioned unnecessary delays with resultant poor maternal and fetal outcomes.

Furthermore, Nigerians love appellations and titles and unfortunately the love of appellation and titles contributes much more to maternal mortality than we know it. Not just that we love to answer Prof, Doc, Chief, Rev, Bishop etc, we also want to be recognised as papa doc, mama fada, nwunye engineer etc. As a result parents go to any extent to get their children into

medical school even when they have no such capacity. I really sympathise with such children for the trauma, medical school put them through and the scar it left on them. Medical education is very tasking and I am sorry not meant for the 'average' student. Feel free to disagree with me here. An ideal medical student must be above the average in terms of intelligence, brilliance, resilience, devotion, duty and responsibility. We do not say it, but many of us here know it and might even have been involved, parents trying to cut corners to get their children into medical school, and while in school, chase around lecturers one after the other at each examination session for short cuts. I have received such guests; unfortunately they met the wrong person. These children after lengthy years graduate from medicine and we hand over 'human lives' to their wits and skills. There may be cases where the outcome has been maternal death, a situation where the woman might have survived had she not sought care in the hospital. Such doctors are not children of the meat sellers in the market, or the cobbler in the village, or the farmer in the rural community. They are sons and daughters of many of us sitting here, the high and mighty, the movers, shakers and controllers of the society. Let us examine our consciences and actions in this regard ethically.

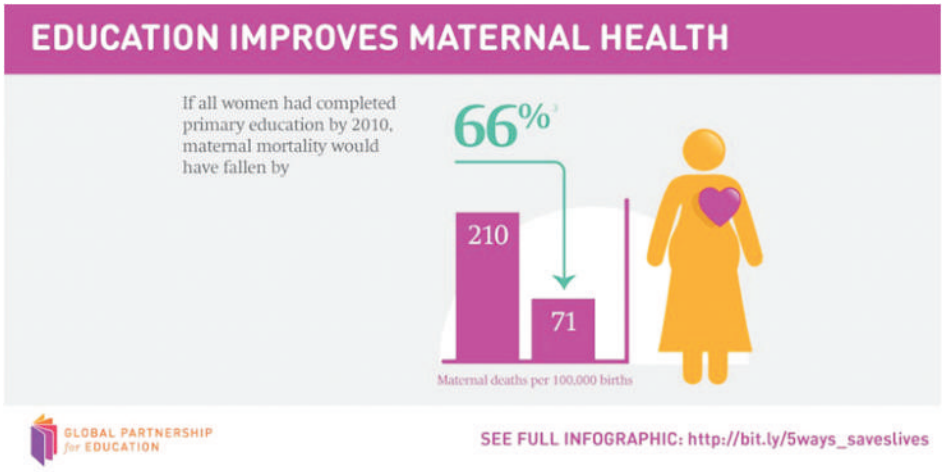
Have our actions contributed to community good, have our actions contributed to the maternal health or maternal death? Whenever we cut corners for our children to become medical doctors when they have no such capacity, we have directly contributed to maternal mortality and we will have to answer for that at the appointed time. Have we done this with good intent (deontology) or for the benefit of the greater majority (utilitarian)? Did we apply practical wisdom in such situations (virtue ethics)?

THE COMMUNITY

Community values crystallise in the family and as such the family reflects the community. Nothing contributes more to maternal mortality than the denigration of and discrimination against women. And this is what obtains and not only tolerated by, but also perpetuated in some communities, often times in the name of culture which at best is self-serving without any moral reasoning or persuasion behind them. These are totally contradictory to the ethical view that upholds each individual's autonomy and self-governance. What is the morality denying the girl child adequate nutrition in comparison to the male child as obtains in some communities? Inadequate girl-child nutrition results in

inadequately developed pelvis, a sure precursor to obstructed labour, a major contributor to maternal deaths. In this way, communities kick-start the pathway to maternal death in childhood. The same pattern is served in education, where the girl-child ranks lower in the perking order than her male counterpart. They are denied education and therefore the opportunity and basic right to self-discovery, self-awareness, self-realisation, self-emancipation and self-fulfilment. In that way, they remain subdued and subjugated to the caprices of men. They cannot self-decide in their own health matters. Men who cannot carry pregnancy even for a second take reproductive health decisions for them. Not surprising, some of them do not and cannot access prenatal services and when they are allowed to, the TBA around the corner becomes of choice. Maternal mortality reports have consistently associated low educational level with statistically significant higher degrees of maternal deaths[4,5,25].

Almost all agencies and publications have posited education as the single most important factor in the fight against maternal mortality[26-28]. By depriving women of necessary education, the community ensures that they cannot achieve equity, economic



independence and therefore remain eternally dependent on men and vulnerable – the stage is now well laid out for maternal death. And when it eventually happens, the community blames the poor nurse/doctor at the hospital, raining abuses and curses on them.

Traditional birth attendants, herbalists, animists and spiritualists dot the rural communities. The communities not only house them, feed them but also protect them. A lot of health mishaps have been traced to these untrained and unskilled charlatans[29]. The community dismisses such mishaps as the Will of God and even goes ahead to praise them. "It would have been worse if we had gone to the hospital" What could be worse than death, I keep wondering? And if perchance they got to the hospital before passing on, the blame will be laid on the hospital while exonerating

and praising the efforts of the charlatans.

Furthermore, the community provides comfort and protection for age-long subjugation of women in the name of tradition. It upholds male domination in all aspects of family life and living. It is taboo in some climes for women to seek health care without the express permission of the husband, who occasionally at the material time of medical emergency may be at a drinking house. In such situations, the complications deepen, no arrangements are made for referral or transfer and above all, no financial backup is provided. By the time the mighty of the family is willing and ready, the woman is already in dire condition. In these same communities, women are not allowed to own properties lest they become empowered. Luckily, recently the Supreme Court of Nigeria passed a law allowing property inheritance by females in communities[30]. We wait to see how that plays out in our communities.

These same communities hold on to myths, superstitions and beliefs that tend to chain women down to their health predicaments. We are all aware of a community where obstructed labour is held as a punishment for the woman consequent upon marital

infidelity. In such a case, the woman is meant or forced to confess admitting infidelity. If she does, she is left to suffer her fate (punishment confirmed) and if she does not, she is also allowed to suffer same fate for failing to acknowledge her iniquity. One was lucky to be brought to the hospital and the family refused blatantly to foot any bill. On her demise, all debts were cleared. In other communities, it is an abomination to take a woman who has fitted while pregnant to the hospital. “It is not a condition for the orthodox medicine; solution must be sought along traditional lines'. The harrowing experiences of such women are so horrible to be put down here.

Meanwhile, the skewed premium placed on having many children especially males by traditional African communities put women and their lives at risk. They are put through pregnancy and childbirth over and over again. The lifetime risk of dying in pregnancy increases with each pregnancy. The commonest risk factor for severe bleeding in pregnancy, which is the major cause of death, is repeated childbirth more than five times (grandmultiparity). In a qualitative study in rural Nigeria involving in depth interviews, we found that many grandmultiparas sought treatment for infertility and

their reasons included acquiescence to the male partner's wishes, desirability for male children, desire for more off springs, replacement of demised children, fulfillment of reproductive potentials and not being "out done" by co-spouses in a polygamous setting[31].

Finally at the community level, I am almost sure that all communities in Southeast Nigeria have local administrative heads apart from the traditional rulers. These are often in the form of Presidents of the various town unions or development associations. Often times, such developments start and end with the name or on paper. It is common knowledge that in a State in southeast Nigeria, the State government on an annual basis distribute millions of taxpayers' money to these development associations for road grading and other similar infrastructure for the benefit of the people. As soon as these are distributed the leaders get fat, and await the next cycle. A futile cycle, while rural roads and basic infrastructure remain in a decrepit state. Result is pregnant women do not have basic health facilities within their communities nor can they access one outside their communities for lack of accessible roads and communication.

We have all listened attentively to the so called negative influences at the community level which tend denigrate and degrade woman and deny them of our common humanity, which eventually leads to unpleasant outcomes relating to childbirth. Some if not most of us, are inwardly fuming and wishing these communities be brought to justice. I love that awareness and zeal. But who is the community? You and I!! Are we not the leaders of thoughts in our various communities, opinion leaders and moulders, the movers and shakers, the foundation upon which the village rests and the *Iroko tree* on which the citizens perch. Yes we are, but we are also the first to condemn the medical centres and health workers when they only complete what we started at the village level. Never have we questioned certain traditions as long as they serve our selfish male interests. Have we not all failed in our ethical duties and obligations to influence culture, traditions and ethos that militate against maternal health? Until we do that, we all lack the moral authority to mourn any maternal death; and questioning it, is out of bound for our consciences.

Our communities are supposed to be our communal nests that promote good for all her members, where the African definition of personhood "**I am because we are"** comes to fullness, and where the Igbo parlance '***Onye***

agha na nwanne ya' finds palpable meaning. Where is the ***Ubuntu*** *(*the essential human virtues; compassion and humanity) of our Africanness . An interesting definition of community on dictionary.com is that of ' joint possession, enjoyment, liability, etc.; and having similar character; agreement; identity. Have we as a community subscribed to the same identity male and female alike and bear pregnancy as joint asset and liability? How have we applied the ethical principles of respect of persons – respect of womanhood, autonomy of person, beneficence (promoting their good) and non-maleficence at the community level? Till we do these, we are all ethically liable for maternal deaths in our respective communities.

THE CHURCH

It is common to hear that of all the Westerners got over to us in Africa, it is only in religion that we have surpassed them. If this is true, it is quite commendable because man's purpose on earth is to be able to achieve unity with God hereafter. Nigerians are very religious. If not, how else can one interpret the multiplicity of Christian denominations and churches all over the country We must give it to the churches; many have contributed positively to health, playing leading roles in the fight against maternal mortality. We must

appreciate such churches, which have set up well-equipped and staffed orthodox facilities and have remained in the fore front of providing health to the population within their catchment areas. There are no better examples than we have here in Ebonyi State. Such facilities need our support and the support of Government to sustain their efforts.

However, on the other hand, it is sad to note that a lot too have contributed to the embarrassing figures of maternal deaths in the country. Ours is a country where some church leaders encourage their members to seek health in the house of God rather than in the hospitals. Annoying in this is that they, and their families seek health in established hospitals when ill health knocks at their doors. Once in the ancient city of Benin, as a junior resident, I stood up to a 'man of God' and told him right to his face, '*if I had my way, right now you will be smelling the rods in the prison'.* He had allowed a woman labour in his church without any skilled birth attendant till her womb ruptured (gave way) and two boys 3.0kg and 2.9Kg respectively were extruded into the abdomen dead, while the woman struggled for her own life. It was a battle but to the Glory of God, she was saved. She could easily have died (Near-miss). This story

rather than be the exception appears to be the rule in many churches. The spiritual authority of the church cannot be overemphasised but men of God of whatever denomination should not overstep their limits.

In the social media more recently has been the issue of financial management in the various churches especially as regards wealth collection and distribution among members. The question remains, how much does the poor get out of this? How many churches in Nigeria set aside fund for maternal health for those who need it? Churches abroad set up foundations to champion maternal health amongst other goals. We all know of Catholic Charities, Salvation Army among others. Can we not replicate these noble ventures here? Must our finances only fund gigantic edifices (good though) or the needs of the leaders? The church is the people, the people are the church. If there is anywhere where virtue ethics and care ethics should flourish flawlessly, it is in the house of God, the churches. The churches ought to take better responsibility for women's health.

TRAINING INSTITUTIONS

The primary institution that admits, trains, moulds and

gifts the medical doctor and most other health personnel to the society is the College or University. The popular saying '*Garbage in, garbage out'* cannot be truer in this situation. The University holds the sacred mandate of recruiting candidates, trains them over the years, and at the end releases them into the society as safe, calling upon the citizenry to entrust their lives unto these certified personnel attesting to their character and knowledge. Ladies and gentlemen of the ivory tower, dons, professors, administrators, how have we fared in producing medical doctors with knowledge and skills to promote and maintain maternal health, in such a way that maternal mortality is reduced to an irreducible minimum? We can all search our consciences and evaluate roles we play in admission, teaching, training and certification of the candidates over the years.

The ideal doctor, will be the candidate with character admitted on academic merit, was well taught and trained in the right environment and with requisite facilities, and at the end had his/her skills and knowledge certified through a valid and well-administered examination. This is the prime function of the university in producing skillful personnel who can

maintain maternal health in the population. Any deviation from this ideal may fuel maternal morbidity and mortality, and whoever from admission to final certification contributed to such deviation becomes a proxy or accessory to preventable maternal death. I reiterate as I had said earlier that some women could still be alive today if not for the intervention of such unskilled medical personnel. And we are ethically liable.

What drives our admissions into the medical schools currently? What is our policy? Do we actually meet the accreditation criteria and deserve the accreditation we have from the authorising entities? Do we apply shortcuts or out rightly deceive or do other things to gain accreditation? Do we provide conducive atmosphere for learning? Do we have all the necessary and requisite facilities including laboratories for effective training and learning? Do we apply ourselves whole-heartedly to training medical students? Are our examinations valid and administered without sentiments, fear or favour? These are ethical and moral questions, which demand answers from each and every one of us.

Years ago when we were admitted into the University of

Nigeria Nsukka, our names were proudly displayed on the notice board in front of the admissions office, and they remained up there for almost the entire duration of our first year. What was instructive was that each member of our class had his/her name up in that list except for one. From the first person on the list, Mr. CO who scored 345 to the last Mr. NC with 272, all made the first list. And when the supplementary list came out it incorporated all those with 271. The only classmate of ours outside the list was a daughter of a Professor in the institution who had earlier chosen University of Ibadan as her first choice and UNN as second. Can we say the same of our admission currently? Anyone involved in admission irregularities may be an accessory to maternal mortality. I have no other interest than humanity to state without fear that admission into the medical school should be for only those above average. Am sure this stirs controversy but let us have an inner sincere meditation within ourselves about it. Those that put so much pressure on the authority for favouritism or pressure their children into medical school should have a rethink. By so doing, are we pursuing the greater good for the greater majority for the larger amount of time? Can our intents said to be others-regarding or self-serving?

While we admit students, it is only hoped we have adequate facilities to train the number we admit. Do we? Accreditation visits are designed to help institutions obtain the basic infrastructure and facilities necessary for training. How these visits have met these objectives remains to be seen. While we appreciate the authority's effort during these visits, a lot remain to be done to save the heads of units from perennial lies to convince the visitors. We must reduce the rate of makeshift or borrowed facilities just to jump the accreditation hurdle. We only shoot ourselves in the feet. From students' hostels to their classrooms and seminar rooms, from the lecturers' offices to laboratory equipment, all form important pieces of the jigsaw needed to produce quality medical doctors. On one cool Wednesday midmorning along the corridors of the defunct EBSUTH, a high ranking management staff saw me and said '*Oh Dr. Umeora, I looked for you the whole of yesterday!'* I quickly replied *'Did you look for me in my office?'* That ended the encounter. The message sunk in. I had no office. How can a lecturer operate optimally without an office within the institution?

Now it is down to the lecturers in the medical college.

Where do we really situate our details? How conscientious are we to the sacred duty we have been called to perform for the society? Are we committed to this duty in the spirit of ethical obligation to produce the good? Do we know that our actions or inactions would impact on maternal health tomorrow? Do our carriage and attitude transmit to the younger ones what they should be tomorrow? Do we devote enough time to our primary duties in the institution? And during examinations, do we carry this out without sentiments? One of my mentors once asserted that examiners who become sentimental during clinical examinations to 'help' the candidates were those who did not teach them when they should have, and were feeling guilty and trying to make up for their deficiency. This appears to be true. We can think of it. Medical school examinations are cost intensive. Students' pay for this but to what extent does the institution fund this examination? As a past head of department, I do not have a good narrative in this respect. Whenever the quality of examination is compromised, the quality of graduates is compromised and all contributors ethically become accessory to any mishap caused by the end products.

Institutions have great impacts on the functioning and direction of the society. The society holds the ivory towers in great esteem and with trust, accepts and believes that impeccable standards are set and maintained. This therefore confers on such institutions the moral responsibility to maintain this trust and as such must be morally and ethically accountable to the public. Institutions with such moral responsibilities must commit to ethics and generate moral profile that is subjected to the public[32]. Moral or ethical profiles provide a platform for continuous discourse and evaluation of institutional actions and activities. Institution must have a recognized pattern of internal decision-making and implementation.

Just as individuals are held as moral agents with moral demands, institutions can also be held as moral agents with moral demands, and can be held responsible for their policies, activities and operations. As moral agents, are distinct from the individuals and personalities within and therefore can be subjected to praise for good deeds or scorn for inadequacies for which they may owe atonement or reparations[32].

Taking all the above together, institutions must evaluate

their actions with regards to admissions into medical schools, training and certification against the foundational ethical principles of non maleficence, beneficence and justice as well as against the virtue ethical tenets of veracity, fidelity and goodwill. Our candid evaluation will determine if we, as an institution play a part in the maternal mortality story within our population.

THE HOSPITAL

Hospital remains the last chain in the complex maternal mortality system. Death occurs here and they bear most of the brunt of what started from the family within the communities. How have the hospitals fared? Are they to blame or are blamed unjustly?

Once the signpost 'Hospital' is erected and exposed to the public, the health facility automatically enters into a fiduciary contract with all who come into it to seek health. The facility is essentially saying *'Come in and we have all it takes to restore or maintain your health'.* This is not a light undertaking. The hospital assumes the moral and ethical responsibility to care for the patient population. Ethics means there is no deception. Hospital policies, facilities, personnel, knowledge and

skill available must be impeccable to perform what they claim to perform. In the case of a tertiary hospital, these include training of medical students, resident doctors, clinical services and research. If the hospital is not equipped and tailored to these, it might as well be deceiving the public and hence morally responsible and accountable for all preventable maternal deaths that occur within its premises.

Apart from the perennial lack of equipment, drugs, consumables and other necessary items for healthcare mainly due to underfunding, the most disturbing trend in most Nigerian health facilities is that of attitude of the staff, which some patients best describe as unfriendly and occasionally as repulsive. It appears some health workers have developed thick skin to ill health, human suffering and even death. They watch people die as part of hospital routine and are not moved. Hospitals must at intervals review their 3 'R' policies (Recruitment, retraining and retention) as it involves her personnel. News, print and social media in Nigeria often are awash with pregnant women dying on the corridors of the hospital without attention. This is regrettable

Next is availability of health workers at material times.

Most health workers do not understand the importance and seriousness of their duties. Most do not understand the essence of timeliness in medical care. It is so sad to hear someone complain '*My boss is so strict and wicked, just because I am 10 minutes late and he is pulling down hell!!* Just ten minutes Enough for 10 women to have died and we do not raise eyebrows! And some of us leave our duty post to go for mass, service, fellowships or other church programmes. Sad again. If only we understand our call to duty. The Latin saying, '*Laborare est orare' (to work is to pray)* needs to sink in into all of us. I wonder if God listens to our supplications in such occasions while we have abandoned the primary duties to which He has called us. It is particularly sad for me to compare this attitude with same Nigerian health workers in Western countries. Believe me, they are never late and never leave before their closing time, majority itch for extra hours. Our system needs re engineering. Our system of positive and negative reward is definitely wrong.

Maternal death in the hospital thrives where care ethics has been thrown to the winds. It is often nice to see health care workers run errands and do all within their purview to care for a sick relative who has come to the

hospital to seek care. But this element appears to be the missing link where the 'other' patient is involved. This missing link is the care ethics. Such 'other' patient is often treated as a burden and a nuisance and left without due care and/or information. In such instances, the care provider relegates the patient's vulnerability, emotion and care needs to the background, as these tend to contradict the care worker's comfort, space and probably schedule. In some instances, the care worker becomes a slave to the clock/time and must get off duty as soon as the scheduled time is over and more frequently even before that. From anecdotal evidence, the worst time for any intervention for an inpatient even an outpatient is during the so-called 'hand over' times. Patients are not just neglected but ignored in order not to intrude into this 'sacred' time and process. Once in the defunct EBSUTH, a patient's relative who needed to pay for the patient was sent back from the Revenue unit where he had gone to pay. Reason 'we are handing over'. Even my intervention yielded little before I escalated it to the chief Medical Director, who then walked down with me and the Director of Administration and the concerned worker was immediately suspended for three months without pay. Care ethics demands that all hospital workers

appreciate the peculiar circumstances of each patient, her vulnerability, emotions, needs and put all in motion to attend to those. In doing so, preventable maternal deaths will be averted.

Doctors or physicians must always bear in mind the prescriptions of the Hippocratic oath, which prescribes 'DO NO HARM' and is the foundation of medical ethics code in Nigeria. The Hippocratic oath also demands an ethical obligation on physicians to perform and carry out their duties competently for the benefit of the patients[33] '*I will act for the benefit of my patient* according *to my ability and judgment'* (Hippocratic oath). Moreover, the Nigerian code of medical ethics holds physicians ethically obliged to protect patients from fellow physicians who do overstep their bounds in medical care[34]. When we do not do this and our colleagues' action result in maternal death, we share the blame. This is part of virtue ethics.

THE GOVERNMENT

Unfortunately the Nigerian health system is still mostly public driven especially at the tertiary tier. Not only is

the Nigerian government signatory to many international charters and treaties dictating adequate health care for the population, she also has the right to life enshrined in her constitution[35] Furthermore section 17(3) of the Constitution under chapter II provides: '*the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons*'. It goes on to provide for emergency treatment in the hospitals in part III under the rights and obligations of users and healthcare personnel thus*: 'Emergency treatment. 20. (1) a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever. (2) Any person who contravenes this section is guilty of an offence and is liable on conviction to a fine of ₦100, 000.00 (one hundred thousand naira) or to imprisonment for a period not exceeding six months or to both'.* So with the above in mind, how come some pregnant women die for lack of emergency medical care? Though one may argue with the adequacy of such constitutional provisions, but they are still nice if adequately ensured. And that is the big question. How has the Nigerian government fared in discharging her healthcare provisions to her citizens? These citizens include pregnant women. Is it ethical and/or morally right to have these provisions in the constitution with

little or nothing to back it up? Does the health budget for Nigeria meet the minimum acceptable recommendation? Does the government have and implement any budget for emergency management in all her hospitals? Or put in another way, are such hospitals timely reimbursed their expenses for such emergency cases? I know of a State that nearly ran down her health institution in the name of free healthcare for her people. Reimbursements were either not made, not adequate or processed very late, and the hospital was left to scamper and scratch to sustain its services.

Constitution provides for adequate health facilities and personnel for all citizens. How far has the Nigerian government met this provision especially in the rural areas? What structures exist for health, well equipped and staffed especially in rural areas? How has the government incentivised health personnel who cluster around urban areas to work in the rural communities? Unconfirmed recent reports have suggested more requests for VISA by demoralised Nigerian doctors to seek greener pastures elsewhere. What is government doing to stem or even reverse this trend, which has dogged the Nigerian health system for decades now? There is no gainsaying the fact that the Nigerian health system is in total disrepair and beleaguered by poor

service quality, chronic shortage of essential materials and medications as well as obsolete and decaying infrastructure[36]. We remember the popular broadcast sometimes in 1983 '..... '*hospitals are now mere consulting clinics...'* one only wishes they were still up to standard clinics at this time. Let us remind ourselves that the WHO ranked Nigeria 187 out of 190 in 2010[6] same position as in 2000[37]. It means in a decade there was no movement. Twenty years after that popular broadcast (2003), only 42% of public facilities in the country were up to internationally accepted standards for obstetric care delivery[38].

What is the government doing to monitor maternal health indices Does government put out correct figures to the public to drive actions One of the saddest days in my life was a day a high-ranking government official in one state declared there was ZERO maternal mortality in that state. I am yet to understand what that assertion was meant to achieve till today. We do not politicise women's lives. It is morally and mortally wrong. In another state, when the MMR figures were disaggregated, it painted a grim picture of a particular administrative centre. Rather than working to improve upon the picture, the local administration went on to

harass and discredit the researcher. Sad! International agencies have easily dismissed maternal mortality data from Nigeria as unreliable coupled with deficient vital statistics records in rural communities resulting in survey estimates with wide margins of error[39]. Finally, some state governments have commendably passed legislations on maternal mortality making each case reportable. Till date one is yet to see any action emanating from such legislation/reports. Implementation remains a regrettable problem in the country.

Has government at every level paid adequate attention to maternal mortality? I regret to say that the answer is a resounding NO! And it is easy to prove. May be we need to read the editorial published in the African Journal of Medical and Health Sciences[40] comparing government's response to Ebola to her attitude to maternal deaths in the same country. While I respect every life lost to Ebola, the response was massive and worthy, but can that be said of the even more lives lost to pregnancy and childbirth? We might all guess the reason for that. While Ebola came in through the upper socioeconomic class and threatened that class, maternal mortality appears more confined to the vulnerable, voiceless and poor

women in the lower rungs of the socio economic class. This brings us to the twin devils that perpetuate maternal mortality in developing countries, poverty and illiteracy.

POVERTY AND ILLITERACY

Who do we blame for the prevalent poverty within the Nigerian state with all her resources and natural and human endowments? Whoever is to blame, the Nigerian state has the capacity and obligation to bring people out of the quagmire and/or ameliorate the living condition. Poverty renders a woman vulnerable to health adversities and it has been said that poverty is both a cause and effect of poor reproductive health state[41] and this is mainly due to lack of access to effective sexual and reproductive health care[42]. Maternal death is an index of poor sexual and reproductive health. Around us, mothers have died for not being able to afford as little as two thousand Naira and no authority ready to pick up the bill. We all have similar narratives. Poverty is prevalent as the underlying factor in the majority of maternal deaths. This simply explains why maternal deaths declined in the era of free maternal care.

Education is proffered as the single most important factor in a successful fight against maternal deaths in any population. Documents show that MMR is inversely proportional to literacy level in any population[26-28.] Around us, illiteracy is high. A society can help only itself and save her citizens from untimely death in pregnancy and childbirth by investing in quality education and making it freely available to and/or affordable by ALL. Please bring back our quality public school (I attended public schools). Education not only empowers and emancipates but also brings about equity in the family and society, important factor in elimination of maternal mortality.

The final question – Can government hold any of her citizens ethically responsible for any case of maternal mortality when she has not functionally and dutifully discharged her legal and constitutional responsibilities to the people?

From the above discourse, one can easily decipher that individually and collectively we all might in one way directly or indirectly have contributed and/or are to blame for any case of maternal mortality. This includes me. We have left ethics and have let our mothers down

and allowed them not to live.

MY JOURNEY SO FAR AND MATERNAL MORTALITY

My view of maternal death was painted by the last case I managed as a medical officer in Lagos as I alluded to earlier. Luckily my residency training was at a centre with zero tolerance to maternal mortality. Any maternal death at the University of Benin Teaching Hospital (UBTH) in those days conjured a sombre and solemn atmosphere to go with it. It was always painful and each case was thoroughly verbally autopsied to uncover the remote and immediate causes of the death, and generate preventive actions against further such occurrences. MMR was really kept so low at that centre. Within months of my absorption into the then Ebonyi State University Teaching Hospital (EBSUTH), not only was maternal death common but also the deaths hardly affected the prevaling mood or atmosphere within the unit/hospital. That got me thinking.

TREND IN MATERNAL MORTALITY

One of my first studies was to review maternal deaths at the centre. This was published in the International Journal of Gynecology and Obstetrics[5]. This was the first

published data on the topic from the centre. We sought to find out the pattern and associations of maternal deaths in the centre over a four-year period (2000-2003). Major findings were a high MMR of 1,884/100,000 live births with adolescents accounting for 23% of this. They also had the highest age group specific MMR of an astronomical 4,104/100,000 live births. Over 81% of these occurred in women in the lower Socio Economic Strata of 4 and 5. Perhaps the breakaway finding in this study was the contribution of infection, which was responsible for 33.3% of the deaths. Haemorrhage or severe bleeding which elsewhere is the leading cause was implicated in 16.7% of the cases (half of that by infection). This study served as a wake-up call in the department, and with residency training properly entrenched, it was possible to strengthen some of the systems and adjust policies to fight this menace. One such system was the daily clinical care audit (morning review), which became consolidated within the department. Infections and bleeding were fought more vigorously. The system was also helped by the free maternal care policy of the state government. The actions paid off because results of the review in the subsequent four years (2004-2007) showed a significant reduction in MMR to

1,008/100,000 live births[43]. More so, not one death was recorded among the teenagers while infections and bleeding were 3rd and 2nd as major causes of death during the period contributing 8.6% and 11.4% respectively. Obstructed labour and ruptured uterus were the largest contributors during this period and accounted for 40% of the maternal deaths. Majority of the deaths were amongst the unbooked and lower socio economic rural inhabitants. This last study called for more concerted effort to solve the obstructed labour debacle.

As a result we sought to examine the contribution of obstructed labour and ruptured uterus to maternal deaths more closely[4]. We did this by examining a 10-year record in a rural mission hospital. Evidently these occurred almost always in the unbooked mothers coming into the hospital when complications have already developed. Risk factors for ruptured uterus were mainly previous Caesarean section scar and injudicious use of Oxytocin. Most of these occurred with the Traditional birth attendants (TBAs) who managed such labours. Using the facilities of the mission hospital, we were able to reach out to many of the TBAs in the communities around and tried to induce them for early referrals. We also did study their (TBAs) roles more

critically. First we looked at women referred in labour[44], in this study, we found that referrals from TBAs were often late with the women presenting in very grave conditions, some dead on arrival. Majority, (76.8%) of the women who laboured with them were referred with obstructed labour, some of whom also had ruptured uterus. The specific MMR for such referrals was an astronomical 4,603/100,000 live births. Going further, we evaluated postpartum referrals from TBAs [45] and found that perineal injuries (29.4%), puerperal pyrexia (22.5%), postpartum bleeding (18.3%) and genital infections (10.3%) were the commonest complications associated with delivery at the TBAs. And delivery there was associated with an even higher MMR of 4,961/100,000 live births.

Of immense concern amongst the TBAs was the lack of adequate awareness and knowledge of HIV/AIDs amongst them. In a cross sectional survey involving 109 TBAs randomly selected from the communities, the practices of asepsis and sterilisation procedures were poor which likely would encourage the spread of HIV/AIDS which they also lacked adequate knowledge of[46]. HIV/AIDS is becoming an important cause for maternal death in sub Saharan Africa.

It was not enough to document these figures. The rate definitely alarmed everyone and something needed to be done. For these, with my co researchers we delved to uncover the facts behind these figures. Apart from the primary characteristics of these women being poor, illiterate, rural dwellers, many more factors were uncovered by several of the studies and included poor health seeking behaviour, which left so many of them unbooked and hence were not availed of the benefits of prenatal care services[10]. Other factors were high parity[25,47], delivery under the care of non skilled birth attendants with high incidence of obstructed labour and ruptured uterus[42,42.] and late presentation[43,48].

The Bamako declaration on Safe Motherhood Initiative (SMI) [49] identified four pillars of safe motherhood, and they include family planning, antenatal care, clean and safe delivery and emergency obstetric care (FACE). Our research centred around these pillars.

FAMILY PLANNING

In 2015[50] we evaluated the contraceptive preferences of reproductive aged women in Abakaliki. Knowledge of contraception was high 83.3% among the respondents

and 69.4% approved of contraceptive use. However, only 28.3% of the respondents were using any form of contraception then. The commonly employed modern contraceptive methods were the male condoms, the oral contraceptive pills, injectables, and the intrauterine contraceptive device. Over half of the users procured their contraceptive products from patent medicine dealers. The main barriers to uptake included desire for more children, religious prohibition, spousal disapproval and the perceived side effects of modern contraceptives. This picture was largely unchanged in the most recent study 2017[51], the level of awareness remained impressive at over 90%. Health workers were the primary source of information on family planning services in about 56% with other sources including church, market places, media and peers. Many of these women never used any form of contraception (45.5%), it was therefore not surprising that many had unplanned and unwanted pregnancies. And those that have ever used, 50.8% of them adopted natural family planning methods and barrier methods (condoms) in 25%. These are methods with high failure rates. Unplanned and unwanted pregnancies are more likely to be associated with significant maternal morbidity/mortality than planned pregnancies. The fear of side effects and

objections by the significant other (50.3% and 33.3% respectively) were the commonest hindrances to accepting contraception. Nevertheless over three-quarters of the respondents believed they did not have enough information on family planning and over 90% will require further information. Family planning is one of the pillars of safe motherhood. The above study proves that we as medical workers and members of society have left the women to source information often times from informal sources, which might be misleading. We left them as far as effective contraception services are concerned, in that way we left them to get pregnant when they are not ready, and in such a way leave them at risk of preventable mortality. We recommended the refinement and up scaling of information available to women of reproductive age on family planning as well as the involvement of the male partners.

ANTENATAL CARE

Our first study in this direction in 2005, was a cross sectional survey of antenatal clinic attendees at the defunct EBSUTH, we noticed a positive correlation between antenatal clinic attendance and the introduction of free maternity services at the centre,

driving the number from 559 in 2000 to 3,254 by end of October 2002. However 47.5% of the respondents sought prenatal care from multiple facilities including formal centres (35%) unorthodox outlets (12.5%). The concurrent use of unorthodox care was more prevalent among the older women aged over 30 years and those with little or no formal education and belonged to the lower socio economic strata. A significant finding however was that 55% of these booked to access prenatal care only in the third trimester, which was late and as such could not have derived the optimal benefits of prenatal care[52].

In a quest to increase antenatal clinic attendance, in another cross sectional study involving randomly selected 1022 clients, we assessed their risk status using the WHO classifying form. Almost 75% of them met criteria for the basic component of the WHO antenatal care model, we therefore advocated the implementation of the model with reduced number but goal-oriented visits in the centre[53]. We meanwhile went ahead to test the popularity of the new model with the end users, it was really enlightening to note that more than half of them would rather prefer the traditional method with multiple visits. It was more reassuring for

them and they believed it afforded more time away from their routines, get used to the facility, fellow expectant mothers and care providers, and provided opportunity to extract finances from their spouses[22].

In our last review in 2012[54], we found out that only 16.9% booked in first trimester while the rest booked late in spite of all previous efforts to uptake early booking. The mean gestational age at booking was 24.3±5.5 weeks. Curiously there were no significant socio demographic or past obstetric experience differences between those that booked early and those that booked late. This means that a lot more needs to be done in this direction. Quality prenatal care bears much positive influence on maternal and perinatal health and hence an important process in the reduction of maternal death. The only parameter that positively influenced early booking was illness in the first trimester. In that case the patient is 'forced' to seek management.

Severe bleeding is one of the commonest causes of maternal mortality globally. Anaemia in pregnancy contributes significantly to this risk. In a large cross sectional study we found that over 58% of booked

mothers were anaemic[55]. They were on blood-forming medications (haematinics). This is grave realising that there are many more unbooked women without the benefits of antenatal haematinics and therefore more prone to the risk of bleeding and maternal death.

CLEAN AND SAFE DELIVERY

Delivery under the supervision of a skilled birth attendant has been shown to be an essential factor in preventing and managing complications during childbirth. The National Demographic Health Survey (NDHS) 2013[56] revealed that 36% of births in Nigeria are delivered in a health facility while 38% only of deliveries were attended by skilled birth assistants. One reason some mothers shun orthodox (especially tertiary care) centres, is the fear of Caesarean delivery. We performed an audit of Caesarean sections in the centre. Not only were most Caesarean sections performed for obstructed labour among the unbooked, the general abdominal delivery rate of 19.6% was within globally acceptable range. We went further to evaluate the utilisation of maternity services across the state at the secondary level within the communities[16] and the finding showed abysmal patronage of maternity services at this level. Worrisome was the fact that only

17.2% of the mothers who had earlier delivered in such facilities were willing to do so again in the future. Women of higher educational attainment and those of lower parities utilised the facilities more than their less educated and higher parity counterparts. Non-availability of doctors, poor quality services, lack of drugs and equipment, poor infrastructure, negative attitude of staff, cost and transport difficulties were factors identified as impediments.

Cost would really not be a problem in a climate of free maternity services, but it still was, as we uncovered in another study[57]. In spite of the widely applauded free services, patients still had to make out-of-pocket expenses and this could be a deterrent to accessing skilled care in labour. Mothers spent an average of eight thousand, three hundred and fifteen (N8,315.00) Naira and twenty-one thousand, eight hundred and thirty-two (N21,832.00) Naira respectively for vaginal and abdominal deliveries respectively.

To improve upon delivery rate with skilled birth attendants, a lot still have to be done to improve upon the knowledge and capacity of mothers to access care at health facilities and more importantly to make services

client-friendly and affordable to the mothers. The male partners should also be motivated to become involved. The picture we got in our study on spousal companionship in labour was not encouraging to say the least[24].

Another nagging problem we uncovered in the course of our studies was the inability of parturients to accurately recall details of previous deliveries, which could impact on the outcome of the current pregnancy and/or labour. Their recall accuracies for the immediate preceding and penultimate delivery events were 43.6% and 41.3% respectively. Their educational attainment but not age or parity had influence on this recall capacity. We therefore recommended the introduction of the Past Obstetric Performance (POP) card, which summarises the patient's past obstetric details to be brought with her in her next pregnancy/confinement[58]. This was introduced in the department.

EMERGENCY OBSTETRIC CARE

When labouring or just delivered mothers present with complications, the health facilities should be well equipped and staffed to handle such emergencies. This

capacity has been designated as key to reducing the high maternal mortality ratio in developing countries.

The importance of blood and transfusion services cannot be overemphasised to counteract the fatalities following severe bleeding. Personal experiences and anecdotal evidence pointed to the fact that so much resistance trailed blood donation and transfusion within the local population. For this we interviewed men and women (who were not of the Jehovah's Witness faith) in the surrounding communities, and were able to come up with the prevalent socio-cultural barriers to voluntary donation of blood for obstetric use in Ebonyi State[20]. The resistance to blood donations was palpable among these largely rural communities with poor education. Most of the reasons were based on misinformation, mistaken cultural and religious dictates and ignorance on the need and safety of blood and blood products. The need for massive enlightenment cannot be overemphasised in this aspect.

In further studies, we found that TBAs and other unorthodox care centres contributed disproportionately to the number of patients brought in for emergency obstetric care[18,44,45]. These included

spiritual homes and unfortunately some nurse-led facilities and primary health care centres. Most, (61.6%) of the referrals came from centres located more than 10 kilometres from the referral care centre and 18.2% were able to access the referral centre within five hours, over 47% spending more than 10 hours. It was not surprising that over 82% of those that suffered mortality spent less than 12 hours in the referral facility. This may also point to the fact that the centre was not fully ready or equipped to handle such acute emergencies. Other important reasons for delayed presentation included resistance of the TBAs to refer the patients, absence of spouse, transport difficulties, financial considerations, peer direction (misdirection rather), strong belief in TBAs and spiritualists and association of orthodox centres with operative deliveries and mortalities. The futile cycle is complete: late referral in moribund conditions → death in the hospital → mortality associated with hospital → delay to seek orthodox care till late and the cycle continues. The delay caused by such delayed referrals from peripheral facilities which eventually leads to delay is accessing definitive management is different from the types 1, 2 and 3 delays propounded by Thaddeus and Maine[17] referring to delays in decision, transportation and institutional

actions respectively. This latter delay is fatal and we termed it the mortal or type M delay[18].

We further found out that the commonest cases referred from the peripheral centres and the TBAs included: obstructed labour, ruptured uterus, severe bleeding, retained placenta, retained second twin, severe pre eclampsia/eclampsia and intrauterine fetal death[44]. Others are perineal injuries, postpartum collapse, puerperal pyrexia and puerperal sepsis[45]. Nevertheless, in the multicentre study on severe maternal outcomes in Nigeria[1,] we documented that the overall mortality index for life-threatening condition was high (40.8%), while median intervention time between presentation and institution of management was an hour which is really a regrettable and may constitute mortal delay, in some cases it was over four hours.

The question is, do we have enough facilities equitably distributed within the state to handle these emergencies in the clinical conditions they present, and within the short window provided for intervention? We have plans to currently evaluate the capacities of health care facilities in the state to offer acceptable emergency

obstetric care.

POST ABORTION CARE

Abortion complications also contribute to maternal mortality. Figures however attributed to this in many of our studies were low[5,25,43,48]. However, it was not entirely surprising because these were hospital-based studies. The abortion laws in Nigeria make abortion services at the present, clandestine. Presentations at orthodox centres were mainly when complications have set in. We therefore evaluated the post abortion services obtainable at the teaching hospital over a five-year period[59]. Abortion complications comprised 41.4% of all gynaecological emergencies managed within that interval, of whom 11.5% succumbed to their complications mostly haemorrhage, infection and pelvic abscess. Unsafe abortion constituted 34.1% of all the abortion cases. Meanwhile, we documented that just about a third of the care providers received formal training on post abortion care service and that there was poor integration between emergency post abortion care services and other reproductive health services at the centre.

TRAINING AND ACADEMIC HEALTH

The quality of care delivery primarily rests more on the quality of medical staff in the facility than on the structure and infrastructure available. As a hospital and department (and I must pay special tribute to the immediate former Chief Medical Director of the Federal Teaching Hospital, Abakaliki (FETHA), Prof. Paul Ezeonu for his vision in this direction). Not only was residency training programme strengthened during his tenure, he also worked hard in conjunction with the department to secure FULL ACCREDITATION from the two postgraduate colleges operating in the country), we intensified training for residents in the department and went the extra mile to improve upon their surgical skills by signing memoranda of understanding with three mission hospitals spread all over the state, to enable the residents acquire expert skills in medical and surgical management of cases in those hospitals. This has paid off and the department and hospital and the entire population have benefited from the success story so far.

After the first 12 months of the programme, we evaluated the impact and it has been a symbiotic (win-win) situation. Both the host hospitals and primary centre (FETHA) have gained. In the host hospitals we noted that there was an attendant increase in uptake of

services, and medical complications were better managed. Though there was an increase in the number of emergency caesarean deliveries undertaken, the overall Caesarean section rate dropped. A significant reduction in maternal mortality ratio to 444/100,000 live births was recorded[60]. On the teaching hospital side, registrars or junior residents reported a 900% and 460% rise in the rates of emergency and elective caesarean sections respectively they were able to perform. Similar increases with regard to gynaecological procedures were also documented. Senior residents (senior registrars) on the other hand, had a 100% and 80% rise in performance of total abdominal hysterectomies and myomectomies respectively. Seventy-five percent of all the residents believed that their surgical skills improved tremendously while 87.5% of the senior residents believed their administrative skills greatly improved also. **We concluded that** obstetrics and gynaecology residents found the posting useful and acknowledged the opportunity afforded them to improve upon their knowledge and skills[61].

For academic health and imparting of knowledge and skill that will help both the present and future students and doctors in the fight against maternal mortality, I have contributed over 50 chapters to 10 text books and

have been the lead editor in three core obstetrics and gynaecology textbooks namely: OUR TEACHER[62] – a comprehensive textbooks of obstetrics and gynaecology, THE GUIDE[63] – *protocol for management of the obstetric and gynaecological patient in the tropics,* and OBGYN STEP BY STEP[64] - *a concise guide to cases and procedures in obstetrics and gynaecology.* Other publications include: THE TRAINER[65] and a Manual for basic ethics in research.

ADVOCACY

The battle against unnecessary maternal deaths must be multi-pronged and multi-disciplinary. It must therefore involve collaboration and cooperation with many actors from the community to the national government levels, hence the role of advocacy. Apart from physical and personal mobilisation and advocacy visits to different groups including government, I used editorial platforms in different peer reviewed journals to drive the process.

In pushing for legislation on maternal mortality monitoring in 2007, I reaffirmed the direction of the *Making pregnancy safer* project which suggested that for effective fight against maternal deaths, more

information outside hospital data on MMR is needed. Information surrounding each death within and outside medical facilities must be harvested and analysed and actions taken consequently to prevent future occurrence[66]. Luckily, Ebonyi State is one of the States in Nigeria with legislation on maternal death monitoring.

As the end date of 2015 for the millennium development goals were approaching and Nigeria was so far from meeting the maternal health goals, we pressed through another editorial, the need to change strategies to make efforts more effective in 2011. We made a case for a re focus on other proximate factors surrounding maternal deaths in Nigeria calling for a creation of Preventive/Community obstetrics units in teaching hospitals staffed with specialists and trainee specialists alike. The unit takes maternal health services to the communities rather than wait in the urban centres for referrals. In this project, the teaching hospital sends out specialists/trainees to peripheral hospitals in the communities to coordinate their clinical activities and create a viable referral system complete with functional ambulances and trained paramedics. In this way the teaching hospital maintains oversight functions over the peripheral facilities within their

catchment area, hence bringing the expert clinical services to rural populations[67]. I am not surprised that years later, FETHA has bought into this arrangement with three peripheral centres in the state.

That same year 2011, we advocated for more action to engender sexual and reproductive health rights of women as a panacea to the high maternal mortality ratio[68]. We based our argument on equity, which demands that resources be distributed according to needs. Poor vulnerable women in rural settings required more healthcare services because of their reproductive roles and recognising the socio economic factors in accessing health. We believed that engendering sexual and reproductive health has to go beyond the usual donor-driven programmes to involve multisectoral, horizontal rather than vertical, human right-based actions and activities to drive educational attainment, economic empowerment, nutrition, housing and environment among those most neglected in the society.

By the end of 2015, Nigeria did not meet up with the Millennium development goal (MDG) 5 targets, maternal health indices remained poor but the world moved on with sustainable development goals. As a

country we have to key in and this informed my next editorial on the topic[69]. I posited that while the world tries to move ahead in post 2015 era transcending the basics, sub Saharan Africa must not lose sight of the basics as enunciated in the eight MDGs. Citing directly from the editorial *'In setting the targets for sub Saharan Africa for the MDG 5, targets could include incorporating basic reproductive health education in secondary and high schools, maintaining an acceptable health facility to population ratio, and health personnel to population ratio, posting and sustenance of a reproductive health personnel to each and every community for service delivery, provision of and access to basic reproductive health commodities including contraceptives, ensuring universal free emergency obstetric care. The MDG goal 5 has not been met as long as sub Saharan Africa lags behind. Gains have been made and in the post 2015 era this momentum needs be maintained and accelerated. There is need to increase citizen participation in the programs through encouraged local ownership and generation of a bottom-up agenda, target setting and indicators. Meanwhile, maternal health goal cannot be achieved in isolation. Efforts towards the other MDGs linked directly or indirectly to health must continue till fruition'.*

ETHICS

My training in ethics courtesy of the South African Research Ethics Training Initiative under the auspices of the National Institutes of Health (NIH), USA opened an entirely new vista of the world to me. Ethics permeates all spheres of human actions including healthcare delivery, from perception of the patient to her management and final outcome of her condition. It is my honest view that all care providers in health undertake some sort of course/training on ethics. Fortunately for me, as the then head of department, I was able to slot in and entrench lectures on ethics at the 4th MB level in obstetrics and gynaecology. I am sure this exposure must have positively impacted on the perception of and delivery of care by majority, if not all of the medical graduates. Furthermore, as a member and eventually chairman of the Health Research Ethics committee (HREC) of FETHA, I have been able to directly and indirectly improve the capacity of many medical students, postgraduate resident doctors and local researchers on issues of ethics in health care and health research. My creative output in ethics has dealt generally with particular challenging scenarios like HIV[70] and infertility[71]. Unfortunately none of these have been

directly linked to maternal health and maternal mortality. However, a particular worrisome issue is the lack of confidence on our research output and figures by international bodies and this has bothered on issues of research integrity. Some of my papers have dwelled on this[72,73]. As a young professional in the field, I believe the field is now let open for me to research into care ethics and virtue ethics as they relate to maternal health and maternal mortality in this environment and beyond. I pray the University research grant will support this laudable venture.

MAKING PREGNANCY AND CHILDBIRTH SAFER

It has been a long discourse and we ask ourselves, after this excursion into the remote and proximate causes underlying maternal deaths in our immediate environment, who is exempt from blame? Somehow at some stages we all might have been morally obliged to stem the tide but we chose to do nothing; we may all have been ethically negligent. Addressing the wide socio economic and situational disparities that fuel and drive maternal deaths in low resource setting must be rooted in ethical values regarding accessibility to

healthcare[74]. These actions must be at the individual, family, and community, institutional and societal levels.

The Individual woman

When a population is vulnerable, the society is ethically obliged to go an extra length to protect them as a matter of equity, this is treating people as individual agents with innate dignity as expounded in the deontological principles. Victims of maternal deaths around us are vulnerable. They are the silent, poor, illiterate and rural suffering masses. Care ethics enjoins us to understand the conditions of the vulnerable in the society and take responsibility for addressing them. They do not easily access health facilities because of paucity of facilities and trained staff in the rural communities. They die because they are wont to propagate you and I, the human race. We are thus morally bound to improve upon the living conditions of these women. And there is no better way to achieve this, than to become committed and loud advocates of girl-child education and nutrition, poverty alleviation and equity. Providing information is not enough, but we must translate such information to knowledge, to boost their agency and decision-making capacity in matters of sexual and reproductive health. This enhances their autonomy.

Education makes a woman employable; it has been shown in surveys that all indicators of employment and labour workforce have positive correlation with maternal mortality ratio in the population[75]. Maternal mortality decreases with improvements in educational efficiency[76]

The Family

Each pregnancy must be seen as a joint couple affair. But for the treasured Immaculate Conception some 2018 years ago, any other pregnancy has involved a man and a woman, including pregnancies via assisted reproductive techniques. Therefore the nine months sojourn of pregnancy should be borne by the two equally concerned parties and the entire family as stakeholders. The woman should be empowered and should have the decision-making advantage in matters pertaining to her sexual and reproductive health. The number of off springs should be a decision taken by the couple and in tandem with her health and family economy. Using wives or women as means for reproduction is against the ethical principle of autonomy and therefore unethical, this is what it seems when she is abandoned or not supported while pregnant. Harmful traditional practices including food taboos should be done away

with.

The community

Often times women bear the brunt of tainted traditional/cultural practices, which continue to emasculate them and subjugate them under the whims and caprices of men. Some traditional beliefs and practices are in direct opposition to the attainment of optimal maternal health. Such practices encourage maternal mortality and should be done away with. The skewed son preference and quest for large family size which lead to grandmultiparity put the women at risk of death for pregnancy and delivery related events. The time for drastic re engineering of some cultural beliefs and practices is now. The community must see each pregnant member as carrying the future of that community, and must feel morally responsible for the successful outcome of that pregnancy. Administrative heads must be just in distribution of community welfare, make efforts/advocacy to ensuring the situation of accessible and functional healthcare facility within the community. They should also partner with government to provide accessible roads and transportation for easy referral and evacuation of mothers with complications. Society must protect her

vulnerable ones, care ethics demands that. With regards to some harmful cultural practices, the rule utilitarian principle wants us to live by rules that, in general lead to the greater good to the greatest number'. The practices that subjugate women are unlikely to pass this ethical test.

The Church

The contribution of missionaries to healthcare in Nigeria has been awesome and appreciated by all and sundry. The church has served as medium for dissemination of health information and even provided platform for health promotion activities. Some more established churches also have orthodox well-equipped and staffed centres that have played major roles not just in maternal health care delivery, but also in manpower training and development. This must be encouraged. Occasionally however, there appears to be tension between faith and medicine. The line must be defined and respected by pastors and church leaders. Healing will be whole only when medicine is complemented by spiritual exercises and not spiritual exercises taking over medicine. Saving lives must remain a basic and fundamental religious duty and this includes pregnant women. Care ethics involves attentiveness to the needs of the people, taking

up responsibility and competence to discharge the responsibility. Spiritual houses, churches or pastors picking up responsibilities they have no competence in, is unethical and have often times resulted in fatal outcomes. They do not produce greater joy to the greater majority (utilitarian). In such cases, practical wisdom is thrown to the winds and counterproductive to human flourishing (virtue ethics). It is expected that men of God act not just with good intentions (deontology) but also would be embodiment of virtues, which should drive their actions.

The training institutions

Academic institutions involved in the training and certification of medical practitioners must remain above board, define and maintain standards from admission through the training to final certification. This standard must also be ensured in terms of facilities and staff. This is not only a legal obligation but also a moral duty. Recently trending on the social media was this thought-provoking message "At the entrance gate of a university in South Africa the following message was posted for contemplation –Destroying any nation does not require the use of atomic bombs or the use of long range missiles. It only requires lowering the quality of

education and allowing cheating in the examinations by the students, -patients die at the hands of such doctors, -buildings collapse at the hands of such engineers, - money is lost at the hands of such economists and accountants, - humanity dies at the hands of such religious scholars, -justice is lost at the hands of such judges --- the collapse of education is the collapse of the nation"

Are we as Administrators, Professors, Lecturers and Staff contributing to the death of our pregnant mothers by lowering the standard of education in our university?

Similarly teaching hospitals must equally maintain standards in terms of structure, infrastructure, equipment, medical supplies and staff. Duties of staff must be defined to avoid strife and tension that impact negatively on patient management. Hospitals must respect the fiduciary contract involving trust that exists whenever a patient walks into the premise to seek medical care. It is an ethical obligation. The tertiary care centres must consider as expedient the suggested oversight function over and collaboration with the lower level centres in their areas of catchment to take care nearer to the people. The issue of competence as

defined in care ethics as it involves the hospitals must include having adequate equipment, supplies and proficient staff to handle cases presenting to the hospital. Where any of these is lacking, the hospital falls short of ethical dictates in patient care.

Health care providers

In matters of death, the health care providers are usually the last living beings that interact with the demised. It is not surprising that often times the blame is laid on them. Physicians must arise above the blame game and treat each patient with the dignity she deserves applying the ethical principles implicit in a duty. Physician must appreciate the humanity in every patient, must recognise their vulnerability and implicit trust on their ability to restore her to health. It is a contract involving trust once more. Any deviation from the tenets of this contract is unethical. The physician must uphold medical ethics encapsulated in the dictum 'primum non nocere' meaning 'first, do no harm' (principle of non maleficence). Apart from other notable ethical principles of respect for persons, beneficence and justice, health care providers must also imbibe the virtue ethics of veracity and fidelity in dealing with patients. The good physician must display

empathy. Care ethics also dictates that we as physicians maintain our competence by continuously updating our knowledge and skill in order to perform the responsibility of taking care of pregnant women. Virtue ethics enjoins us to have the love, fortitude and temperance to apply our skills and knowledge to prevent maternal mortality. If we imbibe these ethical dictates, we can always go the extra mile to save our mothers.

Code of medical ethics also requires that physicians protect patients from colleagues whose actions might be considered injurious to the patients, either by lack of knowledge, skill or humanity. How many of us do this? We as physicians are ethically bound to this duty. And when a woman dies for such our inaction, we remain morally responsible. One ought to bring up for discourse the ethics of physicians saturating the urban centres while leaving the rural population to their fate in the hands unskilled charlatans. It will make an interesting debate.

The Society

Eliminate poverty and illiteracy and we must have conquered more than 75% of the knotty challenges in the race against maternal mortality. And these fall under

the purview of government, and easily attainable in an environment of good governance. Government should be the prime actor in the realm of creating 'the good' as 'good' in the phenomenal world as described by Plato. As a child I trusted government whole-heartedly and believed with confidence all utterances and activities of government as leading to the common good. Unfortunately the definition of common good seems to have shifted in the few past decades. Whatever the case, a responsible government cannot run away form or relegate her responsibilities to the citizens. It is a matter of constitution and basic human right as guaranteed by the different charters Nigeria is signatory to. Perhaps no single indicator reflects the disparities in terms of wealth distribution, socio economic stratification, health systems and structure than maternal mortality. It is a reflection of the society's attitude, political environment, philosophy, motivation and socio cultural balance. Government holds the key and has the wherewithal to address such yawning inequity.

Good governance will surely enhance public health, promote healthcare and improve personal income. Total income is about the most significant determinant of health in developing countries[77]. Increase in health

care expenditure will occasion better access. It is regrettable that while high-income countries spend 8-9% of their gross domestic product, low-income countries spend 2-3% of same on health. The result is high out of pocket expenses on health by families comprising 20 - 80% of their income. World Health Organization also believes that the most important determining factor in a woman's chance of having a skilled birth attendant at delivery was spending on health[77].

CONCLUSION

The greatest defect so far in inquiries into maternal deaths in developing countries has been the almost selective focus on clinical aspects rather than the totality of the social, cultural, economic and political environment[78]. Focus on clinical services, family planning, and emergency care without similar focus on socio-economic and environmental factors will be begging the question and of little benefit among vulnerable population as we have them around us[79]. This is a moral responsibility for all of us. Care ethics demands we do not turn blind eyes to our community and environment as our mothers die in their numbers.

Ethical claims can prompt and define principles, duties and responsibilities and hold individual, community and national actors morally responsible and accountable for achieving the common goal of reduction in maternal mortality[74].

Governments and health related nongovernmental organisations have an ethical obligation to do all in their power to improve upon maternal health indices and reduce the poor maternal mortality figures in Nigeria. The same ethical duties exist for families, communities, institutions and health care facilities to stand up to their duties and provide favourable and healthy backgrounds. For the health care providers/doctors, it is the same and it entails an obligation to prevent the common causes of maternal mortality. This obligation connotes both helping women take preventive measures as well as managing conditions that could lead to maternal death[80].

We as individuals, communities and a society have left our poor vulnerable women to their fate determined by and defined in poverty, illiteracy, inequity and limited access to health care; and they die as a result. Efforts directed against the single symptom of maternal

mortality may only yield temporary amelioration. Everyone, doctors particularly and other healthcare providers generally must be determined to imbibe viable ethics of care[81].

FINALLY

Virtue is a skill, a way of living. Having virtue is doing the right thing, at the right time, in the right way, in the right amount, toward the right people. A life of eudaimonia is a life of striving. It is a life of pushing oneself to the limit to achieve success, success here meaning no woman suffers preventable death in pregnancy or childbirth. This life of eudaimonia implies the desire to constantly keep improving at each moment, improvement in the quality of life of women and care available to them. Ethics of care implores us all to take care of our vulnerable women. We must maintain their dignity and personhood and treat them as end in themselves rather than means of procreation (deontology) so that they can continue in their Divine function of propagating the human race to the benefit and greater good of the greater majority (utilitarianism) and to the Glory of God. The fight against maternal mortality should transcend politics, law, academics, vertical programmes and

isolated clinical interventions; it should hinge on ethics. Ethics provides us a leeway out of maternal mortality. It is evident mothers die because we leave them in their condition in childhood without adequate nutrition and education. We leave them poor, dependent and vulnerable. We leave them without adequate information, knowledge and access to health care when they get pregnant. We leave them during childbirth without adequately trained skilled birth attendants and/or prompt management response to their complications. We leave them to die. They will surely live if we do not leave them!

LOVE AND GRATITUDE

Perhaps no better occasion than this presents me with a platform to appreciate my alter ego MaryJoanne, a consummate paediatrician, a friend, mother, confidant, companion, motivator and adorable, caring and loving wife. Truly I lack suitable words to define her but the word 'angel' comes close to it. A special angel, personalised and Divinely packaged for OUJ you have been. I cannot fully and adequately express the positive power and energy you have brought into my life. It has been success in every aspect of our lives. And you have

made the family flourish with our beautiful and award-winning ladies in the house, MaryFrances, MaryJayne, Claire and Karen. I love you all. My Joy, you are the best.

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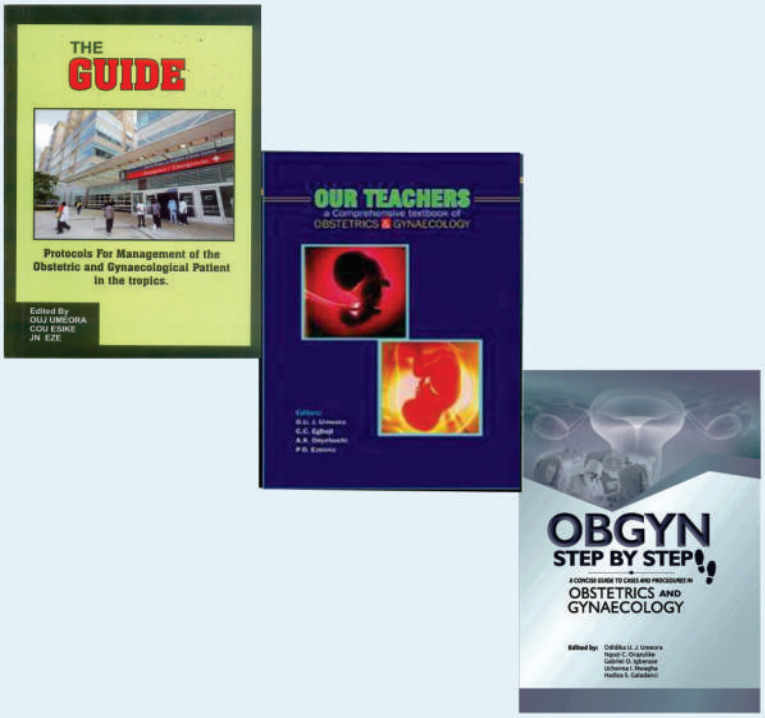

ISBN: 978-978-966-243-2

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