UNIVERSITY OF PORT HARCOURT

SWEET MOTHER: FROM PERILS TO POWER!

AN INAUGURAL LECTURE

By

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ORDER OF PROCEEDINGS

2.45 pm. Guests are seated

3.00pm. Academic Procession begins

The Procession shall enter the CBN Centre of Excellence auditorium, University Park, and the Congregation shall stand as the Procession enters the hall in the following order:

Academic Officer Professors
Deans of Faculties/School
Dean, School of Graduate Studies Provost, College of Health Sciences Lecturer
University Librarian Registrar
Deputy Vice Chancellor Research and Development
Deputy Vice Chancellor Academic Deputy Vice Chancellor Administration Vice Chancellor

After the Vice Chancellor has ascended the dais, the Congregation shall remain standing for the University of Port Harcourt Anthem.

The Congregation shall thereafter resume their seats.

THE VICE CHANCELLOR'S OPENING REMARKS.

The Registrar shall rise, cap, invite the Vice Chancellor to make his opening remarks and introduce the Lecturer.
The Lecturer shall remain standing during the Introduction.

THE INAUGURAL LECTURE

The Lecturer shall step on the rostrum, cap and deliver her Inaugural Lecture. After the lecture, she shall step towards the Vice Chancellor, cap and deliver a copy of the Inaugural Lecture to the Vice Chancellor and resume her seat. The Vice Chancellor shall present the document to the Registrar.

CLOSING

The Registrar shall rise, cap and invite the Vice Chancellor to make his Closing Remarks.

The Vice Chancellor‘s Closing Remarks.

The Vice Chancellor shall then rise, cap and make his Closing Remarks. The Congregation shall rise for the University of Port Harcourt Anthem and remain standing as the Academic [Honour] Procession retreats in the following order:

Vice Chancellor
Deputy Vice Chancellor Administration
Deputy Vice Chancellor Academic
Deputy Vice Chancellor Research and Development Registrar
University Librarian Lecturer
Provost, College of Health Sciences Dean, School of Graduate Studies Deans of Faculties/School Professors
Academic Officer

PROTOCOLS

- The Vice-Chancellor
- Previous Vice Chancellors
- Deputy Vice Chancellors [Admin., Acad. and Research Development]
- Previous Deputy Vice-Chancellors
- Pragmatic Chairman and Members of the Governing Council
- Principal Officers of the University
- Provost, College of Health Sciences
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- Distinguished Professors and Members of Senate
- Directors of Institutes and Centres
- Visiting Principal Officers, Academics and Colleagues
- Esteemed Administrative/Technical Staff
- Your Majesties and Royal Fathers
- Captains of Industry
- Cherished Family, Friends and Guests
- Unique Students of UNIPORT
- Members of the Press
- Distinguished Ladies and Gentlemen.

DEDICATION

To the Glory of God Almighty, whose unfailing Mercies, boundless Compassion, and amazing Grace have been the foundation of my life, and purpose.

To my beloved parents, Prince Daniel Sunny Obiaderi Obaze and Mrs. Angelina Adeke Biose Obaze.

And to every mother, every caregiver, every health worker, and every advocate for health who, with quiet courage and selfless devotion, protect, preserve, and restore life. I say thank you. You are the pulse of this journey.

And to the sweet mothers - those who lived, those we have lost, and those yet to give life - this lecture is for you. May their legacy - and our commitment to protect it - endure.

ACKNOWLEDGMENTS

I express my profound gratitude to my parents, Prince Daniel Sunny Obiaderi Obaze and Mrs Angelina Adeke Biose Obaze, whose guidance shaped my career choice and laid a firm foundation for my life and work.

The support of my family - especially my husband, Chief Hillary Uchenna Ogu - has been immeasurable. I remain deeply grateful for his sacrifices and steadfast love throughout this journey. I also acknowledge, with sincere appreciation, the encouragement of our extended family, notably Chief Kizito Anthony Uzum (Obakpolor of Owa Kingdom), Prince Marcellinus Okechukwu Nlemigbo (Ochiri Ozuo of Mbieri Kingdom), Dr Solomon Obaze, Dr Tony Obaze, Dr Vivian Obaze Bruce, Mr Clement Obaze, Mrs Helen Okere, Mrs Josephine Onyisi Obaze Efenwongbe, Dr Jane Ejime Obaze Aliago, Dr Valerie Obaze, Engr Daniella Obaze, Mrs Esther Obaze, Miss Caroline Ogu, and Mrs Helen Usi.

I warmly recognise Your Royal Majesties - Obi (Dr.) Emmanuel Efeizomor II, the Obi of Owa Kingdom, Obi (Dr.) Benjamin Ikenchukwu, Keagborekuzi 1 CON, Dein of Agbor Kingdom, Eze Vitalis Ubasineke Achilike, Ihieri II Ihitte Mbieri Kingdom.

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I appreciate my colleagues from my Medical School years at the University of Benin, Benin City - Drs Anayo Uche, Judith Elango Uche, Abiye Alamina, Oluwole Ige,

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I express my sincere appreciation to the Vice-Chancellor, University of Port Harcourt, Professor Owunari Abraham Georgewill; the University Inaugural Lecture Screening Committee; the staff of Academic Affairs, and office of the Deputy Vice-Chancellor (Academic); the Students & Faculty of Clinical Sciences; the College of Health Sciences; Director and Staff of University of Port Harcourt Press Ltd., Dean of Student Affairs, Student Union Government and the entire University of Port Harcourt community.

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strengthening my commitment to reproductive health and helping to set the stage for this lecture.

I respectfully thank all from Marymount College, Boji-Boji Owa, Delta State, my Alma Mata. You all are amazing.

To all my relatives & the distinguished entourage from Owa Oyibu in Ika North East Local Government Area LGA, Agbor in Ika South LGA, other LGAs in Delta State & Umudagu Mbieri, in Mbaitoli LGA, Imo State; I say welcome and thank you. Aluaaa, Unu abiala eeeh.

Mr Vice-Chancellor, Sir, with great humility and profound gratitude, I thank you and the entire University administration for granting me the honour of presenting before this distinguished audience.

I thank all volunteers and all who have travelled from far and near to make this event. Finally, I thank everyone present in this hall for your time, your attention, and your: encouragement as I present – Sweet Mother: From Perils to Power!"

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1.0 Introduction

Mr Vice-Chancellor, Sir, distinguished colleagues, family, friends, and invited guests, my lecture is titled: "Sweet Mother: From Perils to Power!" From the first flutter of life in the womb to the breathless cries that herald a new beginning, the journey to motherhood is at once biological, social, and profoundly emotional.

Figure 1. Mrs. Angelina Adeke Biose Obaze

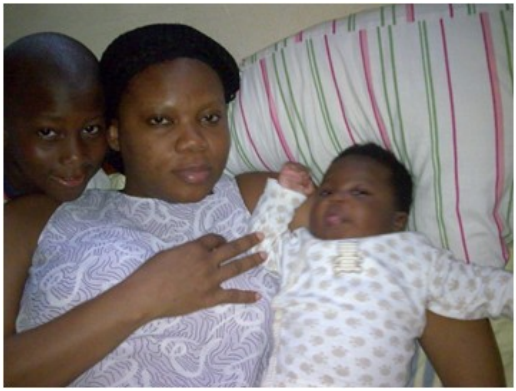

Figure 4: Vulnerability, Possibility& Risk

It is marked by anticipation and vulnerability, possibility and risk. Yet, for millions of women especially across low- and middle-income countries this journey remains dangerously unpredictable, marred by delays, complications, and the tragic consequences of systemic neglect.

My own first journey to motherhood was nearly derailed by complications that threatened both my life and that of my son (now 23, and here with us today). When HELLP syndrome emerged, I almost became a statistic. I thank God who spared my life, and I remain grateful to colleagues and health workers who recognised the danger and had the resources to act. I underwent an emergency caesarean section and emerged a brand-new mother. It could easily have ended differently. From that life spared, a family nurtured.

Figure 5: A life Spared. A family nurtured.

That experience deepened an already growing commitment to maternal health, and it strengthened my resolve to help rewrite the story for many women: from perilous childbirth to powerful motherhood

Figure 6: Operating during a Caesarean Section (CS)

Figure 5: The Joy of Motherhood! From perilous childbirth to powerful motherhood

Every maternal death, the death of a woman while pregnant or within six weeks of childbirth is not merely a medical failure. It is a human catastrophe: a life extinguished in the act of giving life, a child left motherless, a family destabilised, and a nation quietly impoverished. Each one is a story cut short, a promise unfulfilled, and a future interrupted. Yet there is hope,

and my colleagues and I have made the pursuit of that hope our work—through research and reproductive and obstetric interventions, one woman at a time. In this inaugural lecture, I trace the arc from peril to power from the harsh realities of maternal mortality to the transformative possibilities of safe motherhood. I draw on a tapestry of clinical experience, health-systems research, and community engagement and I examine how maternal survival is shaped not only by science and service delivery but also by the social, economic, and political structures that influence women‘s access to care.

Through lived experiences and pathways forged by evidence and policy, we will, in this lecture, explore how survival is shaped by the availability, accessibility, and quality of care and, crucially, by the will to protect women‘s lives. In Nigeria, where maternal health indices remain among the poorest globally, access to care is one of the greatest barriers. And the bitter truth is this: poverty is both a cause and a consequence of poor maternal health outcomes.

—Sweet Mother is more than a nostalgic refrain. It is a declaration of worth and power a reminder that mothers are not expendable. It is a clarion call to policymakers, professionals, communities, and all of us here, to recognise that the state of maternal health is a mirror of our societal values. In championing safe motherhood, we not only save lives; we lay the foundation for stronger, healthier, and more just societies. It is also a call to nurture the girl child, empower the woman, and safeguard the journey to motherhood.

I intend to deliver this inaugural lecture using a framework that examines the perils of the road to motherhood in Nigeria and the progress made along the pathway to the power of ‗sweet mother‘. I invite you to walk with me through this narrative

from perils to power. I will highlight my contributions to clinical care, education, health policy, and research, alongside the collaborations and partnerships that made this work possible. We will revisit selected studies, innovations, leadership roles in professional bodies, and institutional and national impacts including engagement through the Medical Women's Association of Nigeria (MWAN) and the Society of Gynaecology and Obstetrics of Nigeria (SOGON). We will close by returning to ―Sweet Mother,‖ reflecting on the journey so far, and issuing a call to action for government, academia, and civil society.

2.0 Perils of the Journey to Motherhood

The realities of maternal health in Nigeria are sobering and urgent. Despitedecades of advocacy, investment, and intervention, Nigeria remains one of the most dangerous places in the world for a woman to give birth. According to the World Health Organisation, Nigeria accounts for approximately 28% of global maternal deaths, with an estimated 1 in 22 women facing a lifetime risk of dying from pregnancy-related causes (WHO et al, 2025). The leading causes of maternal death postpartum haemorrhage, eclampsia, sepsis, and obstructed labour are largely treatable with timely, skilled care. Yet systemic weaknesses persist, including poor referral networks, stock-outs, and a lack of emergency transport (Macharia et al, 2023; Wong et al 2026). The situation at the University of Port Harcourt Teaching Hospital (UPTH) mirrors these realities (Ogu et al 2018). Our facility data show high rates of late referrals, often arriving in poor conditions (Annual report 2020).

Achieving Sustainable Development Goal (SDG) 3.1 which aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 now requires an

estimated 15% annual reduction, far above the recent rate of just over 2% (WHO et al., 2025). WHO data highlight dramatic regional gaps: in 2023, sub-Saharan Africa‘s maternal mortality ratio (about 454) was orders of magnitude higher than Australia and New Zealand‘s (about 3) (WHO et al., 2025). Nigeria bears a disproportionate burden: although it has about 2.4% of the world‘s population, it accounts for about 28% of global maternal deaths (WHO et al., 2025). Recent estimates place Nigeria‘s maternal mortality ratio around 993 (WHO 2023).

(UNICEF Nigeria, n.d.) among the world‘s highest. These deaths are largely preventable, underscoring the advocacy message that ―no woman should die while bringing forth life.‖

Table 1: Trends in maternal mortality ratio (MMR) by region per 100,000 live births, 2000–2023).

Indicator	Nigeria (2023 or latest)	Global/Region (latest)
Maternal Mortality Ratio (per 100,000 LB)	993 (WHO 2023)	197 (Global, 2023) ~454 (SSA, 2023)
Skilled birth attendance (%)	43%	86% (Global, 2023) 74% (SSA, 2023)
Institutional delivery (%)	39%	~78% (Global) ~64% (SSA)
ANC ≥4 visits (%)	57%	~70% (Global) 57% (W/C Africa, 2023)
Postnatal care (<2 days) (%)	42%	(No consolidated global figure)
Adolescent birth rate (per 1000 girls 15–19)	~200 (about 20% of girls)	41 (Global, 2023) 98 (SSA, 2023)

Source - Author

Global MMR fell 40% (328→197) from 2000–2023, but progress stalled after 2015. In 2023, roughly 712 women died

daily from pregnancy-related causes worldwide. SDG 3.1 aims to reduce MMR to<70 by 2030 (requiring dramatic acceleration(WHO et al., 2025)). Nigeria's high MMR (≈993) reflects persistent gaps in care (WHO et al., 2025).

2.1 The Peculiar Reproductive Health Perils of the Girl Child

Adolescents are young people aged 10 to 19 years. Adolescent childbearing remains high in Nigeria, with serious health, social, and economic consequences. The Nigeria Demographic and Health Survey (NDHS) 2018 found that 20% of girls aged 15–19 were already mothers or pregnant. Rural–urban disparities are stark: 27% of rural teens, compared with 8% of urban teens, had begun childbearing. Education is a major determinant: 44% of teens with no education had begun childbearing, compared with only 1% of those with more than secondary schooling (NDHS 2018).

Globally, adolescent birth rates are declining (41 births per 1,000 girls aged 15 19 in 2023) (WHO, 2024), but they remain highest in sub-Saharan Africa (about 98 per 1,000) (WHO, 2024). Nigeria's rate (about 200 per 1,000; around 20%) is roughly double the sub-Saharan Africa average. Adolescent mothers face higher risks of eclampsia, sepsis, and other complications, and their infants face higher risks of adverse outcomes. Preventing teenage pregnancy through education, protection, and access to contraception is therefore an essential part of reducing maternal deaths. Every woman was once a girl. The health of the girl child is inseparable from the health of the woman, the mother, and indeed the nation. Yet girls face disproportionate risks child marriage, gender-based violence, school dropout, menstrual poverty, and lack of access to sexual and reproductive health education.

My work with MWAN, the Ford Foundation, the Paediatric Association of Nigeria, the International Paediatric Association, and school health programs has focused on empowering adolescent girls with accurate information, leadership opportunities, and access to services. We have delivered hundreds of talks in secondary schools, launched hygiene and dignity campaigns, and engaged parents and teachers to support girl-friendly environments. Our adolescent health outreaches use drama, debate, and peer education to build confidence and skills. The health of the girl child directly translates to the health of the woman. Early interventions such as proper nutrition, access to adolescent reproductive health services, and protection from harmful practices lay the groundwork for safe motherhood and lifelong wellbeing. My work in adolescent reproductive health, including community outreach and policy engagement, reflects this belief. I have seen firsthand how adolescent-friendly health services can alter life trajectories, reducing the incidence of early pregnancy, unsafe abortion, and preventable maternal deaths.

A nation that fails to invest in its girls forfeits the dividends of a healthy, productive female population. From school-based health initiatives to advocacy campaigns under MWAN and other platforms, I have championed girl-centred strategies to ensure every child can thrive. Families must nurture, protect, and educate their daughters. Governments must create enabling environments where girls can live free from violence and discrimination and grow into empowered women.

Looking after women starts with looking after girls. When we do this intentionally, the benefits ripple across generations. As we have argued, “Failure to invest in the health of this largest generation in the world‘s history jeopardises earlier

investments in maternal and child health, erodes future quality and length of life, and escalates suffering, inequality, and social instability." Adolescence is central to global health goals - physical, mental, sexual, and reproductive health; reductions in injuries; lower incidence of HIV; and prevention of chronic substance misuse. When young people are engaged positively, societies can reap considerable demographic dividends. Nigeria stands to gain if it prioritises the reproductive health and social wellbeing of its youthful population: by reducing preventable mortality and morbidity that limit human capital, by addressing risks that shape adult health, and by improving the health of the next generation (Ogu et al., 2018).

At the policy level, I advocate for the inclusion of adolescent-friendly services in state and national plans. Our research has documented both the barriers and the enablers to girls' access to care. (Ogu et al., 2020), the dividends of investing in girls are immense: delayed marriage, reduced maternal mortality, better educational outcomes, and stronger economies. Let us plant well in girlhood, so we may reap a generation of empowered women tomorrow who are sweet mothers in the making.

2.2 My Early Days as a Maternal Health Researcher and Advocate

I was born on March 25, 1973, at the General Hospital, Agbor, Delta State. From my earliest days, I was drawn to the work of care and healing. My journey into medicine was inspired by my father‘s conviction that I had a deep desire to help others - a conviction that shaped my commitment to service, especially for women; whose voices are often unheard and whose lives are endangered by what should be a natural process of childbirth. After completing my MBBS at the University of Benin in 1999, I did my housemanship

and National Youth Service (NYSC) at the University of Port Harcourt Teaching Hospital (UPTH). These early years exposed me to the critical challenges women face during pregnancy and childbirth, and to the structural weaknesses in our health system that perpetuate preventable deaths.

One pivotal experience came during my NYSC, when I was appointed Field Officer for the Magpie Trial a global, double-blind, randomised controlled study assessing magnesium sulphate in the treatment of pre-eclampsia (Magpie Trial Follow-Up Study Collaborative Group, 2007). Pre Eclampsia is a pregnancy complication that occurs in the second half of pregnancy and characterised by high blood pressure, protein in the urine and adverse maternal-fetal outcomes. The experience strengthened my interest in maternal health research and introduced me to international collaboration. Little did I know that my own first pregnancy would later be complicated by severe pre-eclampsia and HELLP syndrome, resulting in an emergency caesarean section. I later wrote up this experience in a paper published in 2005 (Inimgba, Jamabo & Ogu 2005). From these deeply personal and professional encounters, my journey as a maternal health researcher and advocate took on renewed urgency.

3.0 Pathways to Power

3.1 Pathways of Progress: Clinical, Policy, Community Interventions and My Journey

The perils of motherhood are real and persistent and so must be our pathways of progress. Across Nigeria and other low- and middle-income countries, evidence, innovation, and collective action are beginning to reshape the landscape of maternal health: from the clinic to the community, and from the policymaker‘s desk to the delivery room.

I have contributed to this growing body of knowledge. My academic path has been firmly grounded in the University of Port Harcourt and the University of Port Harcourt Teaching Hospital, UPTH, where I rose from Registrar to Consultant, from Lecturer 1 to Professor. Along the way, I earned Fellowships of the West African College of Surgeons, the National Postgraduate Medical College of Nigeria, and the International College of Surgeons. I also obtained a Master‘s in Reproductive Health and am engaging in a PhD in the same field.

Throughout this journey, one question has remained central: How do we keep mothers alive and improve maternal health at scale? In pursuit of answers, I have contributed to and led research efforts and public health interventions focused on quality of care, patient experiences, and health-systems strengthening. I began my residency in January 2003 at the University of Port Harcourt Teaching Hospital under the mentorship of Professors Briggs, John, Akani, Ikimalo, Okpani, Uzoigwe, and others. Early on, I co-authored conference abstracts, including work on patient satisfaction in maternity care presented at the 2003 SOGON Conference in Port Harcourt.

My involvement in evidence-based practice has expanded. I served as a research assistant in the Gynuity Ventures misoprostol trial for incomplete miscarriage, now a WHO standard. I attended the WHO Training of Trainers on Evidence-Based Reproductive Health in 2005 and the WACS Emergency Obstetric Care course the same year. During this time, I co-authored several publications spanning maternal mortality, HIV/AIDS, adolescent post-abortion care, and rare obstetric presentations. These appeared in journals such as the

Nigerian Journal of Medicine, Journal of Medicine and Biomedical Research, and Tropical Journal of Obstetrics and Gynaecology. (Jamabo & Ogu, 2005, 2005, 2008; R. Ogu et al., 2006; R. N. Ogu et al., 2005).

Progress begins with improving the quality and reach of clinical care. Skilled birth attendance, emergency obstetric care, and antenatal and postnatal surveillance remain cornerstones of safe motherhood. Safe motherhood is the effort to ensure that all women receive the care they need to remain safe and healthy throughout pregnancy, childbirth, and the postpartum period. My contributions to clinical practice include facilitating over 50 training sessions in emergency obstetric care for healthcare workers across the 23 local government areas of Rivers State. Since 2009, I have contributed to the training of close to one hundred resident doctors and thousands of medical students. I have also served as an examiner for the National and West African Postgraduate Colleges in the Faculty of Obstetrics and Gynaecology since 2014.

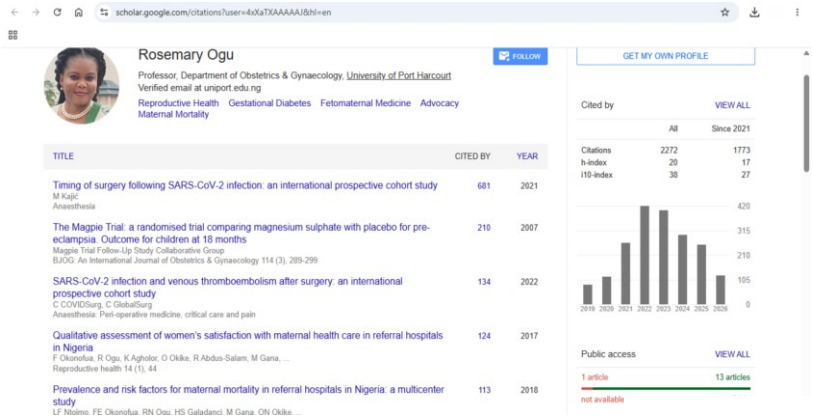

Figure 6: Rosemary Ogu Google Scholar profile

In our clinical work, my team & I have supported innovations, such as improved screening for blood glucose during pregnancy, to prevent and manage gestational diabetes mellitus. We have also supported the implementation of the WHO Safe Childbirth Checklist to reduce preventable morbidity and mortality, and the E-MOTIVE bundle of interventions for the prevention of postpartum haemorrhage.

Through facility-based audits, our team identified key service gaps, including shortages of blood products and delays in surgical decision-making. In response, we introduced evidence-based labour ward protocols, trained staff in basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC), and partnered with facility leaders to develop and implement strategic plans to improve antenatal care. These included innovative payment approaches that reduce out-of-pocket payment at the point of care, fast-track systems such as pre-packing frequently used commodities, and the use of digital information materials to strengthen health education (Maduka & Ogu, 2018; F. Okonofua, Randawa, Ogu, Agholor, Okike, Abdus-Salam, et al., 2017; F. E. Okonofua, Ogu, et al., 2018; F. E. Okonofua et al., 2022).

Having delivered thousands of babies and done hundreds of caesarean sections, I have made the discovery that clinical advances are only sustainable when supported by strong systems and political commitments. This realisation fuelled my passion for leadership and advocacy for policy changes, especially as it relates to maternal health. My team & I have been involved in leading health-related associations and groups since 2005. As State President of the Medical Women‘s Association of Nigeria, Rivers State Branch, I led the team that attracted funding from the Ford Foundation for Adolescent Sexual and Reproductive Health Interventions in rural communities in Rivers State.

Figure 7: Reaching riverine, hard-to-reach communities — because care must travel to where women live.

My team and I implemented the Gestational Diabetes Mellitus Control Programme in the Niger Delta for four years. Based on our findings that GDM can be detected and prevented through universal screening, we worked with state policy makers to scale up screening for GDM at health facilities across the state and documented our success story as a research publication. Again, as National President of the Medical Women's Association, I led the association in a partnership with the African Centre for Excellence in Population Health and Policy Bayero University Kano, Pathfinder International and the Centre for Communication and Strategic Impact CCSI to implement advocacy and communication interventions for the adoption of the E-MOTIVE (E- Early Detection and trigger criteria, •M-Massage of Uterus, •O- Oxytocic drugs, •T-Tranexamic acid, •IV- IV Fluids, •E- Examination & Escalation) bundle of interventions to prevent and control postpartum haemorrhage in 16 states in Nigeria. This is funded by the Gates Foundation.

Through these activities, I have become a champion for women's reproductive health and rights, having learned that some of the most transformative interventions emerge from the ground up.

Figure 8: Champion of Women Reproductive Health

Communities are not passive recipients of care; they can be active agents of change. Through women's groups, male-involvement initiatives, faith-based partnerships, and community health volunteers, health behaviours and norms are being reshaped. Culturally sensitive health education, birth-preparedness planning, and community transport arrangements can help families act early and decisively. My own engagement has included facilitating male involvement for adolescent and maternal health in Ataba & Unyeada (Andoni LGA), leading community rallies and town-hall meetings to promote antenatal care—including screening for gestational diabetes—and participating in radio and television programmes to raise awareness about the three

delays that drive maternal mortality: delay in seeking care, delay in reaching a facility, and delay in receiving quality healthcare.

At the heart of these interventions lies a powerful truth: no single actor or sector can address maternal mortality alone. The pathway to survival is multidisciplinary, multisectoral, and deeply rooted in equity. It demands that we align the clinical, the policy, and the community and that we do so in ways that are context-responsive, scalable, and sustainable. The journey from peril to power is long, but it is not without progress. These pathways illuminate what is possible when intention meets innovation and when science is delivered with compassion.

3.2 Maternal Health Pathway: A Research Synthesis

Co-authors and I have published over 50 articles on risk factors for maternal mortality, the challenges of providing quality maternal health services, interventions, recommendations, and key implications. These studies have employed a variety of study designs ranging from observational to interventional. A summary of the key take-home messages from these published studies (Dohbit et al., 2019; John et al., 2016; Kasso et al., 2020; Maduka & Ogu, 2018a, 2018b, 2020; Ogu & Alegbeleye, 2018; Ntoimo et al., 2018; Ogu et al., 2022, 2022; F. Okonofua et al., 2019, 2023; F. E. Okonofua et al., 2014, 2019, 2020, 2022; F. Okonofua & Ogu, n.d.; Omawumi et al., 2023) reviews factors influencing maternal outcomes and the key implications for moving women from perilous childbirth to safe motherhood.

Figure 9: Capacity building of Primary Healthcare Staff on Emergency Obstetric Care

Figure 10: Capacity building of Medical Students

Figure 11: Our Mothers, Sweet Mothers.

Figure 12: Our Babies.

Factors Influencing Maternal Health Outcomes

1. **Socio-demographic & structural factors:** poverty/financial barriers; low education and autonomy; gender inequality/early marriage; cultural norms (e.g., fear of Caesarean Section CS, reliance on Traditional Birth Attendants TBAs); distance/transport; system constraints (e.g., strikes, staff shortages).

2. **Health service access & utilisation:** antenatal care (booked vs unbooked), skilled birth attendance, postnatal care, emergency obstetric care (EmOC), and family planning uptake.

3. **Quality of maternal health services:** provider competence (EmOC, Infant and Young Child Feeding IYCF, Home Based Life Saving Skills HBLSS), availability of essential medicines (Magnesium Sulphate $MgSO_4$, Tranexamic Acid TXA, Oxytocin), respectful maternity care, private sector/referral quality, and supportive supervision/ Quality Improvement QI teams.

4. **Interventions & programme inputs:** community approaches (Community Health Workers CHWs/safe motherhood promoters, male involvement, community-directed malaria-in-pregnancy actions); health system strengthening (training, task shifting, supervision, mHealth reminders/hotlines); and financial/policy levers (free maternal care, conditional cash transfers, performance-based financing, Primary Health Care PHC revitalisation/Primary Health Care Under One Roof PHCUOR).

5. **Mechanisms of change:** increased ANC and skilled delivery; improved provider competence; reduced delays in seeking/receiving care; improved birth preparedness; greater uptake of life-saving interventions ($MgSO_4$, TXA, IPTp); and improved community awareness/norms.

6. **Maternal & newborn outcomes:** reduced maternal mortality; fewer complications (postpartum haemorrhage, eclampsia); reduced stillbirths and neonatal deaths; increased contraceptive uptake; and improved patient satisfaction/experience.

Key Implications

- Use the pathway to map barriers (structural, access, quality) to specific interventions and expected results.
- Select indicators across the chain (coverage, quality, timeliness, commodities, experience of care) rather than outcomes only.
- Prioritise actions that reduce delays and strengthen EmOC readiness (skills, supplies, referral and supervision).
- Combine demand-side (community/financial) and supply-side (facility quality) strategies to sustain improvements.
- Use mechanisms as a checklist when designing evaluations or theories of change.

Table 2: Perils, Paths to Progress and Power Outcomes: A synthesis of research papers by Ogu et al

Perils of Motherhood	**Pathways for Progress**	**Actions for Power Outcomes**
Unbooked mothers account for most deaths	ANC is lifesaving	Expand ANC access & awareness
Post-partum haemorrhage and eclampsia account for maternal deaths	Clinical interventions save lives TXA & $MgSO_4$ reduce mortality	Ensure availability & provider training
Provider skill gaps drive mortality	Quality of care matters	Train, supervise, support providers
Absence of skilled health workers and poor male involvement	Leadership engagement and advocacy for male involvement works	Scale these programs
Financial barriers kill. Cost prevents ANC & facility delivery	Insurance and subsidy programmes increase delivery uptake	Expand free and subsidised maternal care
Lack of technology impedes care	Health improves ANC attendance	Integrate digital tools into PHC
Gender inequality & stigma reduce care-seeking	Sociocultural norms shape outcomes	Promote gender equality & education

Source: Author

3.3 Stories from the Field

Beyond data and diagrams, maternal health is lived and felt in blood, in breath, in decisions made at midnight, and in silent prayers whispered by bedside mats. In my years of service, I have stood at the intersection of life and loss, privilege and poverty, and I carry with me stories that statistics alone cannot tell.

I recall a young woman from the outskirts of Port Harcourt who arrived at the teaching hospital in obstructed labour after a two-day delay. Her local facility had neither the capacity nor the transport arrangement to manage her case. By the time she arrived, exhausted and frightened, her baby had no heartbeat. Her uterus was ruptured. She was barely alive. But with emergency intervention, she survived. Her words to me the next day *"Doctor, I died but came back"* still echo. Her survival was not guaranteed; it was fought for.

Then there was the rural outreach in Rivers State, where I met a mother of five who had never seen a doctor, never attended antenatal care, and could not read or write. Yet she had profound wisdom about her own body and a fierce determination to live. It was during our intervention that she was diagnosed with severe anaemia and pre-eclampsia. She received urgent care, and both she and her baby survived. She later became a volunteer in her community, telling other women, *"Don't wait until you're dying before you seek help."*

These are not isolated stories. They are part of a larger narrative of women navigating complex realities, making impossible choices, and surviving despite the system, not because of it. But they are also stories of strength, solidarity, and transformation.

In outreach settings across Nigeria from urban slums to remote villages, I have witnessed the profound impact of bringing care closer to where women live, of empowering women with knowledge, and of listening to their voices. Time and again, these encounters reinforce a central truth: when we listen to women, trust women, and invest in women, their survival is not only possible, it becomes probable.

These stories give science a heartbeat. They are the pulse of survival. They remind us that behind every intervention is a life and behind every life is a legacy worth protecting. I have decided that my legacy would be protecting these legacies.

3.4 Women's Health and Sustainable Development

Women are not only the bearers of life they are the caregivers, educators, farmers, entrepreneurs, and informal health providers of society. Investing in their health is therefore not just a moral imperative it is a development strategy. The Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality), emphasise the need to reduce maternal mortality and ensure universal access to sexual and reproductive health services. However, progress has been uneven. My work has aligned with these global goals through community-based interventions, policy advocacy, and research. For instance, our MWAN-led cervical cancer screenings have contributed to early detection and prevention for hundreds of women and girls. In partnership with international organisations, we have piloted youth-friendly clinics, promoted HPV vaccination, and trained birth attendants on respectful care. These efforts illustrate that women‘s health is a prerequisite for prosperity. When women are healthy, families thrive, children stay in school, and communities are more resilient.

Table 3: Women‘s Health and Sustainable Development: A synthesis of the perils, implications, and paths to power from my research findings

Peril	Implications for Women's Health	Paths to Power
1. High maternal mortality (especially from PPH, eclampsia, obstructed labour)	Preventable deaths remain high due to delays, poor management, and lack of skilled care.	Strengthen emergency obstetric care; ensure availability of oxytocin, misoprostol, magnesium sulfate; improve blood banking; enforce WHO/FIGO protocols.
2. Low antenatal care (ANC) utilisation & high unbooked deliveries	Women who skip ANC present late with complications, increasing mortality.	Expand ANC access; reduce costs; community sensitisation; male involvement; mobile health reminders.
3. Poor quality of intrapartum care in health facilities	Even facility births may be unsafe due to poor skills, disrespectful care, and weak systems.	Retrain providers; implement clinical audits; improve respectful maternity care; strengthen supervision and protocols.
4. Sociocultural barriers (fear of CS, traditional beliefs, gender inequality)	Women delay or avoid facility care due to fear, stigma, or lack of autonomy.	Community engagement; empower women; address myths; involve traditional/religious leaders; promote girls‘ education.
5. Financial barriers to maternal health services	High out-of-pocket costs push women to cheaper, unsafe alternatives.	Expand free maternal health programs; conditional cash transfers; insurance coverage for poor households.
6. Weak primary health care (PHC) systems	PHC facilities lack staff, equipment, and governance, reducing access to essential MNCH services.	Strengthen PHC under PHCUOR; task-shifting; supportive supervision; community health workers; infrastructure upgrades.
7. Inadequate community engagement & health education	Lack of awareness leads to late care-seeking and preventable complications.	Scale community-directed interventions; health talks; male involvement; behavioural change communication.
8. Poor data systems & weak maternal death surveillance	Without accurate data, health systems cannot respond effectively.	Strengthen MDCDSR; improve routine data collection and evidence for planning and budgeting.
9. Limited government investment in maternal health	Underfunded systems cannot deliver quality care or sustain interventions.	Increase budget allocation; prioritise maternal health in national development plans; ensure accountability.
10. Fragmented stakeholder coordination	Duplication, inefficiency, and poor impact tracking.	Establish coordinated multi-sectoral platforms; align NGOs, government, and community groups.

Source: Author

4.0 Recommendations and Conclusion

4.1 Recommendations

The time for appeals has passed. What Nigeria needs now is decisive leadership, funded implementation, and measurable accountability—so that preventable maternal deaths end in our facilities and communities.

We already know the life-saving package: quality antenatal care, skilled birth attendance, rapid emergency obstetric care, postpartum surveillance, family planning, and a functioning referral-and-transport chain. Our deficit is execution—weak coordination, inconsistent financing, commodity stock-outs, and poor enforcement of standards.

Preventing maternal death must be treated as a national development deliverable—tracked at the Federal and State levels like security, education, and the economy. Ministries, Departments and Agencies must align budgets and performance targets around one outcome: timely, respectful, high-quality care for every pregnant woman.

Recommendations (targeted actions):

- **Federal Government (FMoH/FMoF/Health Insurance):** Release and transparently track the Basic Health Care Provision Fund (BHCPF) at full statutory levels; ring-fence maternal and newborn commodities (oxytocin, magnesium sulphate, tranexamic acid, antibiotics, blood products); and expand financial risk protection (federal/state-supported health insurance) so no woman is denied emergency care because she cannot pay.

- **Rivers State Government and all States:** Make comprehensive emergency obstetric and newborn care (CEmONC) available 24/7 in every senatorial zone;

operationalise an emergency ambulance/referral call system in every LGA; and ensure at least one functional, staffed primary health centre per ward with continuous powered electricity, water, and essential drugs.

- **Hospital leadership (UPTH and tertiary facilities):** Set and enforce time-critical standards (e.g., decision-to-incision and blood-to-bedside turnaround); maintain a labour-ward ―never-stock-out‖ list; institutionalize MPCDSR with action tracking; and publish quarterly quality dashboards (maternal near-miss, PPH response times, eclampsia case fatality, referral delays).

- **Professional bodies and health workers (SOGON, MWAN, Nursing/Midwifery Council):** Scale competency-based training and re-certification in BEmONC/CEmONC, respectful maternity care, and PPH/eclampsia bundles; strengthen supportive supervision and mentorship; and make adherence to evidence-based protocols non-negotiable across public and private facilities.

- **Primary health care systems:** Extend clinic hours where needed, integrate pregnancy danger-sign screening at every contact, and ensure rapid escalation pathways from PHC to higher levels supported by functional communication and feedback loops.

- **Communities, traditional/religious leaders, and families:** End the normalisation of delayed care-seeking. Promote early booking for ANC, birth preparedness, and savings/transport plans; protect girls from child marriage and sexual violence; and support women‘s autonomy to seek care when danger signs appear.

- **Private sector providers and TBAs:** Establish clear referral partnerships with mapped facilities; stop high-risk deliveries outside skilled settings; adopt standard triage and referral documentation; and participate in state-led quality improvement and reporting systems.

- **Development partners and donors:** Fund systems, not stand-alone projects, strengthen supply chains, blood services, workforce retention, data systems, and emergency transport. Tie support to jointly agreed indicators and local ownership and invest in implementation research that scales what works.

- **Universities and researchers:** Prioritise translational research that improves quality of care at scale; Charge the institute of Maternal & Child Health, embed evidence into curricula and clinical governance; and sustain partnerships that convert findings into state and national policy.

4.2 Conclusion

Final Reflections and the Road Ahead: A Call to Action So That No Woman Should Die Giving Life

Mr Vice-Chancellor, Sir, distinguished ladies and gentlemen, the facts are clear and the losses are unacceptable. Maternal mortality in Nigeria is not inevitable, it is a symptom of choices we have tolerated: delayed care, weak referral systems, gaps in quality, and financial barriers that turn complications into funerals. If we have the knowledge to prevent these deaths, then we have the responsibility to end them.

My vision is therefore not aspirational, it is actionable:

- A Nigeria where maternal health is treated as a top policy priority—planned, funded, and tracked.
- A Nigeria where every woman receives timely, respectful,

and skilled care in pregnancy, labour, and the postpartum period.

- A Nigeria where evidence guides practice, and every health worker is trained, equipped, and supported to save lives.
- A Nigeria where death reviews are non-punitive, routine, and relentlessly converted into system improvement.

To reach this future, we must move from sympathy to systems: strengthen primary health care, ensure 24/7 emergency obstetric care, restore dignity in maternity care, and remove out-of-pocket payments as a barrier to life-saving treatment. Every delay we reduce is a life we can keep; every protocol we enforce is a tragedy we can prevent.

For my future Path:
There are specific impact goals my colleagues and I are committed to achieving for the greater good: to have more positive impact on the wider community by ensuring happier homes, spared the tears and sorrow of complicated childbirth.

We are determined about transforming the care women receive and hope for the support of all towards the following:

1. Establishing a Pharmacy and Blood Bank in the Labour Ward
2. Setting up a Revolving Theatre/Delivery Pack Fund
3. Relocation of the Department of Obstetrics & Gynaecology to her Permanent Site
4. More research on cost benefit analysis
5. Infrastructural developmental research to reduce maternal mortality.

In tandem, we are conducting PhD-level research into overcoming barriers to antenatal and delivery care sustainability through biopsycho social interventions.
As I reflect on this journey through medicine, mentorship, and

maternal health, I return to a simple truth: we will not solve this with lone heroes. As the proverb says, “If you want to go fast, go alone. If you want to go far, go together.” Maternal survival demands coordinated action-government, hospitals, professional bodies, communities, families, and partners moving in the same direction.

This lecture has not been about me alone, but about a collective duty: to protect women in the very act of giving life. It is about the mothers whose strength sustains our homes, and the girls whose futures carry our national promise. Let us say it plainly: **maternal health is not a “women’s issue.” It is a human, justice, and development issue.**

No society can claim progress while preventable childbirth deaths remain routine.

As we look to the future, let us refuse to normalise preventable deaths. Let us insist on care that is timely, respectful, and safe every time, for every woman, in every community. Let us build systems that work, cultivate leadership that listens, and train the next generation to lead with both evidence and empathy. Let us ensure that every sweet Mother rises above the perils of today to embrace the power of tomorrow because when mothers thrive, humanity flourishes. **And let this be the legacy of “Sweet Mother: From Perils to Power!”** that we turned knowledge into action, action into survival, and survival into the strength of families, communities, and nations.

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CITATION

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Department of Obstetrics and Gynaecology,
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A proud daughter of Owa Oyibu in Ika North East LGA, Delta State, Princess Rosemary Nkemdilim Obaze was born on Sunday 25th March 1973. She attended Etuno & Okundaye Primary Schools in Igarra, Edo State and Boji Boji Owa, Delta State between 1979 and 1984. Rosemary began her academic journey with excellence that would become her trademark. Finishing tops from the prestigious MaryMount College, Boji Boji Owa in 1990, where she won the National Association of Women in Science & Technology Prize for Best Science Girls in Nigeria, she went on to study Medicine. She earned her Bachelor of Medicine, Bachelor of Surgery MBBS with Distinction from the University of Benin in 1999 and later obtained a Master's degree in Reproductive Health from the World Bank Centre of Excellence in Reproductive Health and Innovation CERHI domiciled in the University of Benin.

Her professional journey has been defined by scholarship, service and leadership. As a young doctor at the University of Port Harcourt Teaching Hospital UPTH in 2001/2002, she contributed to the landmark international research MAGPIE Trial on the use of magnesium sulphate in pre-eclampsia management. She completed her residency training in Obstetrics and Gynaecology at the UPTH in 2008, earning the fellowships of both the National Postgraduate Medical College of Nigeria and the West African College of Surgeons (FMCOG, FWACS).

She was appointed Lecturer I in February 2009 at the University of Port Harcourt where she rose to the rank of Professor of Obstetrics and Gynaecology within nine years. She has served with distinction as the Director of the University Youth Friendly Centre, Head of Department of Obstetrics and Gynaecology, and now the 9th Deputy Vice Chancellor (Academic). Her tenure has been marked by innovation, improved service delivery and impactful engagement with students and patients alike. During her tenure as Director of the Youth friendly Centre, she led the setting up of the University‘s Sexual Harassment Policy.

Professor Ogu‘s leadership extends beyond the University. A passionate and long-standing member of the Medical Women‘s Association of Nigeria (MWAN). She has served at state and national levels, culminating in her role as National President in 2023. Internationally, she has contributed to the Medical Women‘s International Association (MWIA) and the United Nations Commission on the Status of Women (UN CSW).

A respected researcher with a strong focus on adolescent, newborn and maternal health, Prof. Rosemary Ogu has over 70 journal articles published in peer reviewed journals, 15

chapters in peer reviewed textbooks and 67 papers delivered at conferences. She is currently Co-Principal Investigator of the Accelerating the Implementation of Maternal Newborn Child Nutrition Health (AIM MNCNH) Project, driving innovations to improve health outcomes across Nigeria.

Beyond her many accomplishments, Prof. Ogu is known for her warmth, energy, resilience and unwavering commitment to excellence. She is supported by her husband, the Odi' Ukonamba 1 of Ihitte Mbieri, Imo State; Chief Hillary Uchenna Ogu, and their two sons Kasarachi & Hasianachi.

Distinguished Ladies and Gentlemen, please join me in warmly welcoming an exceptional scholar, Icon, & leader; Professor Rosemary Nkemdilim Ogu.

Prof. Owunari Abraham Georgewill
Vice-Chancellor