

MDGs & SOGON: Mortality, The Media & Corporate Nigeria
- *The Third Olusola Adewole Ojo Memorial Oration*

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It is a privilege to be invited to give this year's Professor O A Ojo Memorial Lecture. I had no idea that such an opportunity would come my way when I sat in Professor Ojo's tutorial group in his office with others in 1972. He was an awe-inspiring and exacting task master but we did have some additional non-academic rewards like the end-of-posting dinner in his home, a happy carryover of his Trinity College, Dublin days where my father also studied medicine.

Professor O O Ladipo in his SOGON 2nd Memorial Lecture in 2005 has given a comprehensive citation of Professor Ojo's life and times and I have no scoop or new angles and therefore heartily recommend that lecture to refresh your memory. I will not even plagiarise his biographical work because his own account is widely available for comparison and I will soon be caught out. In summary Professor Ojo was born in Ibadan in 1927 and went to CMS Grammar School, Lagos and in 1948 he went to Trinity College Dublin University Ireland to study medicine obtaining a Bachelor of Arts, 1st Class in 1952 and qualifying in medicine in 1954. After a stint in UK hospitals and UCH, Ibadan he returned to the UK to Glasgow and Belfast and was the best candidate at the MRCOG examinations a Gold Medalist and was the second Nigerian to pass the MRCOG.

On return to Nigeria in 1961 he worked as Consultant Obstetrician and Gynaecologist to Island Maternity, General and Creek Hospitals. In pursuit of his academic learning he joined the University of Ibadan in 1963. His research in anaemia in pregnancy was rewarded in 1964 with an MD from

Trinity College, Dublin-the first research degree from his department. In 1968 he became the first Nigerian and probably the first black African Professor of Obstetrics and Gynaecology.

His research work covers a wide range in the specialty but Professor Ojo is widely regarded as the father of Family Planning in Nigeria. He was also a great teacher among an array of good teachers in the UCH at that time and certainly stimulated my own interest in O and G and contributed the big kick necessary for me to receive a Gold Medal in my MBBS exam in O&G when Professor Gebby was external examiner. He was keen on further training of all cadres as well and also contributed greatly to enriching the literature with books and papers.

The Third Professor Olusola Adewole Ojo Memorial Lecture was delivered at the at 41st Annual Scientific Conference and General Meeting of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) in Ibadan, Nigeria on 16th November 2007

Professor Ojo was a foundation member, Secretary General and later President of SOGON and the first Fellow of the West African College of Surgeons, a Council member and 2nd Vice President.

He will be remembered for his upright, forthright attitude, his imposing stature and his numerous contributions to uplifting of

healthcare for our women and especially their reproductive education and rights. One may disagree with some aspects of Family Planning but one must doff one's hat to the efforts made by Professor Ojo to make a difference to the lives of women in Ibadan, his home city, in Nigeria and Africa in general.

But where do we go from there. Many stand on the shoulders of unacknowledged giants. Many giants lie in unsung graves with no biographies launched loudly in their names. Many merely dance on the graves of giants finding petty excuses to avoid building on the legacies. This lecture series will ensure that Professor Ojo is remembered but it must be a lecture series of building further on his formidable foundation. Professor Ladipo has led the way and dealt with 'MDGs: A Reality or A Mirage' and I intend in this lecture to proceed to the next step. In his conclusions as to why the achievement of the MDGs appears largely a mirage, Professor Ladipo highlighted a lack of funding, poor governance and poor rights issues as needing to be addressed if the MDGs are to become a reality. Since then not a lot has happened. Too many decisions are in the hands of the incompetent, the corrupt, the disinterested and those lacking vision, fiddling while our women die from easily preventable maternal mortality causes. Are we also guilty in SOGON???

This lecture series is about legacy and a key legacy is what we have left behind to residents.

A Note of Self-Criticism & a Plea for Residents
 Professor Ojo was instrumental in getting reciprocity between Part I MRCOG and Basic FRCOG.

1. Are we fair to all concerned especially our PG professional colleagues in training?
2. Are our examiners current, open to new

- and other ideas & objective?
3. Do examiners assess proposals, dissertations, books and exam papers and orals promptly, critically and fairly?
 4. Are candidates informed of their failure to qualify for an examination in good time or on the morning of the exam having traversed the country and read hard for six months?
 5. Are there SOGON 'Time and Motion' studies to ensure that candidates, our future SOGON colleagues, are not DELAYED THROUGH NO FAULT OF THEIR OWN?
 6. What are the avoidable and preventable causes of such delays, sometimes for a year or more?
 7. Can we eliminate some causes like mistakes, design, neglect, misplaced documents, locked away documents by travel of examiners?
 8. Can candidates sue for wrongful loss of 6-12 months of their lives?
 9. Who reviews the reviewer? Even judges have supervision and judgement.
 10. Who arbitrates on behalf of aggrieved candidates even if they dare not complain?
 11. IS THERE AN OMBUDSMAN?
 12. SHOULD CANDIDATES SUBMIT A prophylactic EXTRA COPY OF WORK for a back-up examiner to save them 6-12 extra months?
 13. Are there a regularly reviewed and monthly monitored Progress Sheet/Time Line/story board opened for each stage of a candidate's progress through the training.
 14. Curriculum requirements: Should more than 1 month's Ultrasound Training be required to keep USS well within the province of O & G?

Unfortunately many examiners at all levels find adaptation difficult and our students suffer the consequences in increased examination failures. There is danger in

Figure 1: VVF Prosthesis Theory

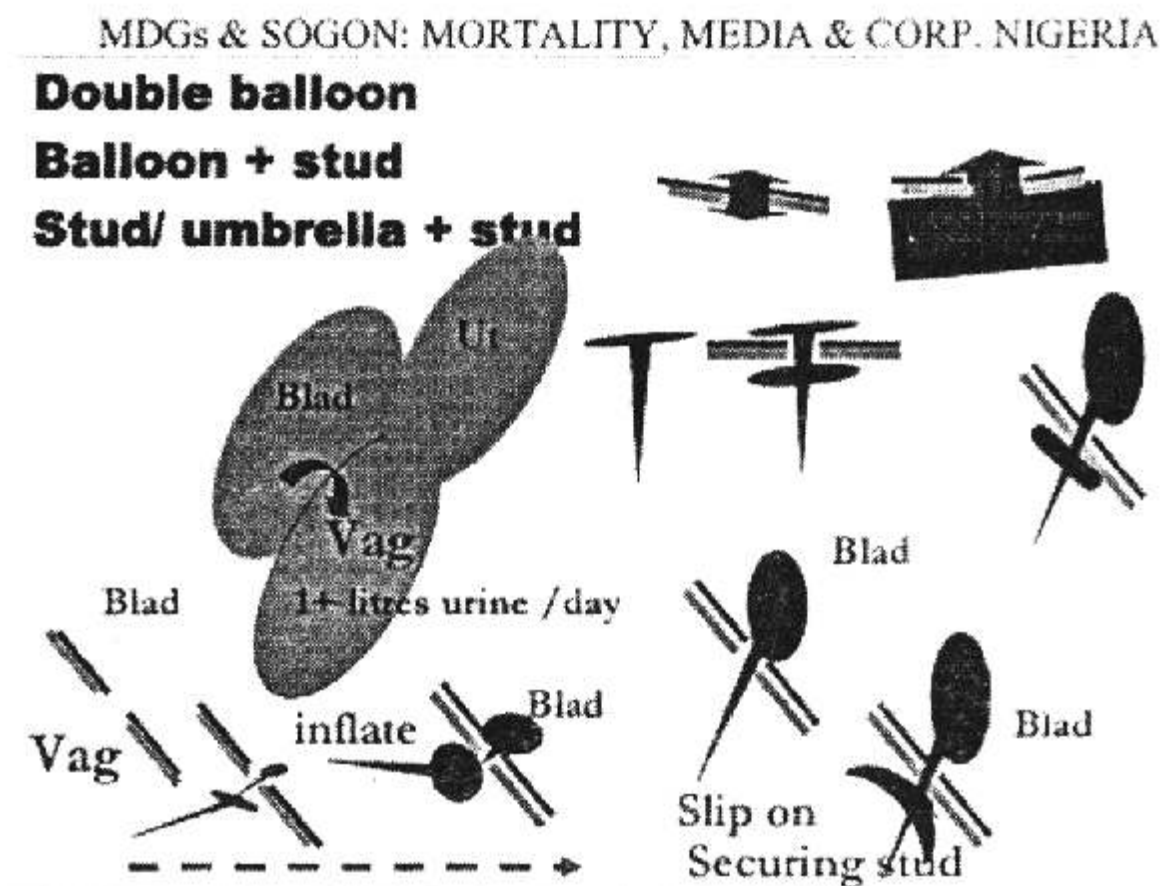


Fig 2 VVF Prosthesis 2

dedication to dogmatic adherence to old principles. We are taught that there is no never in medicine but often forget this fact. Bear in mind that even VVFs are no longer required to mature for 3-6 months before surgical intervention in some hands.

Perhaps a review panel should study these and other points raised by examiners and residents as reduction in Maternal Mortality requires many more SOGON members as part of the strategy?

What are the Maternal Mortality statistics we are fighting to reduce?
 An Maternal Mortality Rate of 800/100,000

live births, 54,000 deaths a year, 4,500/month; 150/day; 6/hour by the end of this lecture. We also have 1 million perinatal deaths a year or 2739/day and 114/hour by the end of this lecture. What about the morbidity????

Some Issues
 1. The area of 'Theoretical Gynaecology' is just like theoretical physics but neglected in medicine where not enough questions are allowed and we, especially our examiners, need to be much more open to new and different ideas. Dogma is good religion not good medicine.
 2. An example of Theoretical Gynaecology

which has troubled me over many years is the lack of a 'Care Window' between the occurrence of a VVF and the surgical cure of that VVF. Fig 1,2. Who among us is developing or modifying, with the cardiac and vascular surgeons and technologists, an inflatable blind-ending catheter or stent or 'umbrella'. Such a device which when inserted into the vagina and passed through the VVF into the bladder, or visa versa, will seal the VVF on inflation, on slight traction or by urine pressure on bladder filling until surgery can be performed? It could be kept in place by a fitted 'washer' slid up the catheter to the VVF hole.

This will effectively stop the leaking of urine, the odour, vulval excoriations and being ostracized, the psychological and social family structural damage of our traumatized mothers, often without babies, until VVF surgery can be performed. Of course the risks of infection, iatrogenic fibrosis, iatrogenic enlargement of the original VVF size and contribution to difficulty in subsequent surgery will have to be considered.

Such problems are unquantifiably miniscule compared to the maximum miserable life of a VVF sufferer and the family unexpectedly estranged from her. It is easy to suggest that a man will just get another wife but remember that all people, even the husband of the VVF patient, have unexpressed feelings of TLC, Tender Love and Care. No one wants to lose a child and a wife at the same time. If VVFs were in men I am positive that such a prosthesis would be routine by now.

When will we witness the announcement of a VVF buttonhole or cufflink stud VVF inflatable prosthesis? Surely that would be worth a N500,000 or N1m SOGON Prize for Gynaecology at next year's SOGON Conference? Money donated by MTN or Oceanic Bank or Shell or Chevron??

3. Countering Stigma in O & G: C/S: Scar no

de show for face; scar no de show for pikin; No be failure; na GSM- God Save Mothers; Sex of baby; MISPLACED BLAME: Your husband/man has given you a Girl/Boy; Infertility-MISPLACED BLAME: Almost 50% caused by the man.

4. Do you think that NAFDAC's and the HIV-AIDS Media Campaigns have had a positive or negative effect on your patients? If yes, why do we in SOGON not follow that example for the Top 20 SOGAN Life skill Messages?

5. When last did you last receive a SOGON/NMA Newsletter of serious academic substance to change your practice in the field?

6. Are you in possession of SOGON or NMA Step by Step Guideline Pamphlets for the management of certain key medical issues like Rape, HIV/AIDS etc?

7. Are you in possession of SOGON or NMA Guideline Pamphlets to inform patients and relations about various medical conditions and 'Dos and Don'ts'.

8. When last did you watch or hear a clear cut Maternal health Advert in pidgin or local languages to stimulate the massed manhood and womanhood of Nigeria to take the correct medical steps to escape the dangers of what we in SOGON have known all along and what the WHO calls the Most Dangerous Day in a child and woman's life The Delivery Day?

9. Are you, as a highly trained professional, satisfied with the role of the media, electronic and print, in support of the execution of your professional responsibilities?

10. What percentage of your patients remembers the Last Menstrual Period LMP. How can you increase that figure?

11. Should we change the name LPM to the more accurate First Day of the LMP or fdLMP.

12. What percentage of your patients' husbands and brothers, or indeed the male population or even the female population

actually knows that the male is responsible for the sex of the baby?

13. What is the commonest congenital / inherited disorder in Nigeria? Why is sickle cell so difficult to prevent? No way or no will or ignorance? Whose responsibility?

14. What percentage of Nigerians know they should do their sickle cell genotype while in school and before falling in love in order to reduce the number of sickle cell patients in pregnancy you will see?

15. What percentage of your hospital beds has Insecticide Treated Nets?

16. What percentage of your patients is ignorant about Coca Cola, Always, Dettol and MTN and Celtel? None and why is that? Will that information save their lives?

17. Bearing in mind that there are 70,000 schools, 800,000 classrooms and nearly 1 million teachers and millions of market women and petty traders, staring at bare empty walls, are there SOGON Posters we as SOGON should put out there to help prevent maternal and infant mortality in future generations by acting NOW? A poster in the ANC is seen too late.

18. Bearing in mind that grassroots are where the problems of ignorance are, can SOGON champion and canvas for community Youth Centres which would be the seat of all wisdom at local level.

19. If we had one Youth Centre in every ward and put all the necessary SOGON and other informational posters in them and had them run from year to year by NYSC members we would change mindsets and reduce medical complications.

20. SOGON has a wealth of experience. Should SOGON go to the next level of national information dissemination and seek private public partnership funds for Vacuum /filling? A permanent or traveling Exhibitions of Girlhood / Womanhood / Motherhood or join with the NMA to set up You & Your Health Exhibition / Museum and fill this glaring and yawning gap in public enlightenment/entertainment which would

spill into the electronic media?

Is SOGON too silent? Even if we are doing well, should we be doing more? Can we do more? Will our doing more save more lives and make our job easier? Have we missed an opportunity to influence the outcome of a woman's pregnancy in more ways than just taking the delivery or performing an expert Caesarian Section for an Immediate Neonatal Death or a Fresh Still Birth at the end of an ignorant and neglected potholed and painful pregnancy road? Should we intervene earlier in the woman's life cycle of conception ANC- delivery-infancy, adolescence/schooling, adulthood, childbearing, aging and dying? Instead of waiting for the woman to come to us should we not be going to them when they are receptive to educational 'life skill' messages? In school in particular. Even if there are caveats against some topics we must offer a syllabus or curriculum content to schools that arms the youth for the battles of life-including Safe Motherhood.

Perhaps we are at the wrong end of the funnel-catching babies of ignorant and ignored mothers instead of catching their brains in school and educating future mothers to help themselves to a safe delivery. At the very least we should add this weapon to our Safe Motherhood armory. Let us look at some stakeholders with influence in society: The media and Corporate Nigeria.

A Neglected Weapon of Mass Development in achieving the MDGs is The Elimination of Mass Medical Ignorance by Energising the Media and Corporate Nigeria.

Why do we have huge medical problems in Africa?

Partly because the Media in Africa has failed the masses and medicine.

* The media is too commercialized, forgetting its primary role, to educate, in an ignorant society. It is at the beck and call of

the highest bidder commercial interests peddling soft drinks have larger budgets than 'life skill message advocates: traditional medical practitioners are well healed and free to advertise any claim even using O & G textbooks on TV.

* Advertising restrictions on orthodox medicine leave the people with one-sided information

* Why do we in Africa needing so much development waste so much media opportunity to develop the mind?

* Why does Bill Gates spend \$m buying AIRTIME IN THE AFRICAN MEDIA FOR AIDS adverts TO SAVE Africans in Africa?

* Bill Gates/ UNAIDS, UNDP etc should insist on African governments meeting them halfway and providing all the advert space as their own contribution to helping to enlighten their own people.

* UNIFEM/UNICEF advertises about gender issues on satellite TV but not in the local media to the locals where the local crimes are committed and could be prevented. This is a media failure because the media can receive such adverts free of charge but refuse to use them for our own people's benefit. Shame on the orders from above that would rather have blank spaces on TV than life skill messages that would reduce Maternal Mortality Rates and Infant Mortality Rates. Far faster than SOGON can.

We have huge problems with the media in Africa

* We are 90% ignorant of 'life skill messages'

* 10% relevant educational programming

* We waste 90% of that same airtime on mindless programming and music. Mindless airtime

* 10% useful to knowledge

* This knowledge gap is a MISSING LINK

* SOGON should annually identify the Top 20 Social Messages to be given to the media which should distribute such messages to continuity announcers, journalists,

producers, directors and script writers for use daily. They should also be given to Corporate Nigeria and Corporate Africa

* What is the cost of airing or newspaper printing a Coca Cola or MTN commercial advert Vs a Maternal Mortality Message? Shamefully it is often the same as if the social message is a profit making message, profiting the organization producing the message. The media even tells groups to remove their logo if they want a discount.

* In these days of adverts everywhere and particularly Coca Cola & MTN & Always adverts in their millions how many Millions of Maternal Mortality Prevention adverts do you see daily? Nil, or one or two HIV AIDS ads. A Missing Link.

* COMMERCIAL MESSAGES OUTNUMBER LIFE SKILL MESSAGES BY 1 MILLION TO ONE

* What is the annual commercial advert budget in billions in Nigeria? 10-15b

* What is the annual medical advert budget for Maternal Mortality Prevention adverts and other NON AIDS adverts? Nil or less than five million nationwide FOR 50 MILLION WOMEN

* THAT IS WHAT WE ARE UP AGAINST Finding the Space & the Budget for Social Messages

* The SPACE already exists....but is currently wasted

* The BUDGET could be very small, zero in many cases.

* A Public Private sector partnership could create the following

DRINK COCA COLA/Use MTN cards and

Attend a good Antenatal Clinic early in pregnancy/Do your breast exam every month/ Go early to hospital if sick/Do your sickle cell test/ Go to only good clinics.

How do we in medicine convince Advertising Gurus, CEOs and Corporate Affairs Professionals that a 21st Century African Advertising Revolution demands that they open their advert space and their purse-

strings to Social Life Skill Messages-the MISSING LINK in reducing health mortality?

Fig 3.

* That Mono-Message Adverts concentrating on the Product are myopic and morally wrong in developing countries with high ignorance levels.

* To release some of their advert space, 5-10% for Missing Link customer enlightenment messages to keep them alive longer to buy more products improving the bottom line.

* That such activities are good CSR and show 'care for the customer' beyond product sales.

* A subsidiary social message on every advert would result in Mutual Reinforcement, Positive product memory, keep clients/customers alive longer.

The Budget and the Space for MM & other Social Messages:

Neglected areas for Media and Corporate coverage include all the method suggested for HIV/AIDS advocacy strategies.

1. Space, 5-10% in Corporate Newspaper adverts, billboards, posters, pamphlets, on packaging, health inserts into packets
2. Nollywood scripts and role playing stars
3. Use Celebrities like Ovularia/Zebrudia
4. Football for male directed adverts on female issues
5. Music/music stations Youth
6. Films
7. Cable/DSTV 'Breaking News' type of runner tape for social messages during any visual programmes
8. Fillers by continuity announcers, unused advert space
9. Text Messaging

NB: costs are negligible as the space is already there, just wasted!

Is this suggestion an unjustified imposition on 'poor' Corporate Nigeria and Corporate Africa? Not if you look at corporate profits, the stock exchange and AGMs.

Let us look closely at Corporate Nigeria.

What are the 10 common contributions of women to Corporate Nigeria's mega-billion naira success?

1. Soaps/Cosmetics/Creams/Body lotions
2. Sanitary towels/tampons
3. Hair care
4. Food/Medicine
5. Child products
6. Books/school/home
7. GSM boom
8. Banking/money matters
9. Trading/Business/Professionals
10. Gifts from/for men/children

Ask yourselves 'Who makes the most money from our women folk?'

Corporate Nigeria. What do our women get in return? Very little.

A query for Corporate Nigeria & Nigeria's Selfish Advertising and Media Strategy

* Ask yourselves this question that may have escaped your attention. Who makes the most money from our womenfolk? Corporate Nigeria. What do our women get in return?

* What contribution to anti-Maternal Mortality activities is made by Corporate Nigeria compared to the huge profits

* How much gets back to the customer to keep them alive to buy future products?

* Note the horrendously wasteful expenditure on transient advert and noisy promo campaigns T-shirts, posters, face caps, pamphlets all now in the dustbins and on rubbish heaps with million naira billboards pasted over by the latest product adverts

* In our underdeveloped/developing country we wrongly use an advertising strategy used in an advanced country where there are few 'needs'

* Could the money be better targeted for a better return and achieve the same result of increased sales for the Corporate Nigeria?

* YYYYYEESSSS!!!! The answer is 'yes' and the challenge is to our companies and our

advertising gurus to come on board with cheap advert strategies for reducing maternal mortality among the female customers

* Much of Corporate Nigeria unfortunately uses and abuses Nigerian women offering the least possible in return... a few corporate coloured CSR, corporate responsibility T-shirts, face caps and computers...drops in the mighty ocean of need.

* What is the Value Added to, VAT, the lives of women by Corporate Nigeria in exchange for massive financial female patronage?

What is the VAT on the lives of women that Corporate Nigeria MUST make?

* In exchange for massive financial female patronage?

* Providing Cheap/Free advertising space

* Give up Wasted Space of the Advert Media to the Mission Link...Social Messages

* Extra missing Link messages on Billboards, Pamphlets, Packaging, Inserts, Airtime

* More costly: Fund...Budgetary Vacuum in Social Messaging to be filled by money and space and airtime provision by Corporate Nigeria, Media basic responsibility, not SR. NOT Foreign AID No, NO, NO

* Only a developed country can afford to squander so much valuable space and time...

* Advertisers must undergo a Nigerian/African Advertising Revolution... and promise to VAT every advert...

* Include a New Component in every advert... the Social Message

HOW CAN WE GET THE MMR MESSAGE ACROSS TO CORPORATE NIGERIA??

* You have shares, friends, family in corporate power

* There are many females in corporate power...are they doing enough?

* You are members of IoD, Stock Exchange, Boards of Banks and Corporations

* SOGON Presidential Public Letter of Commendation/Condemnation powers

* Prizes/Recognitions and Awards, RRA,

for being MAD & Making A Difference

* Advertising: Imagine for one day a year when all advertising will be only adverts on Health and other social issues... ridiculous? No

* Imagine every advert you see today being a social message advert... Impossible???

* Conference between SOGON, NMA, Corporate Nigeria, Media Advertisers & The Media on 'New Strategies for Advocacy in achieving MDGs'.

* Will Corporate Nigeria and the media 'tolerate' the use of 'their' advertising space for such good?

* How much further along the road to reducing Maternal Mortality would we be if all our adverts had carried life skill messages these past five years?

* Corporate Nigeria could lead the world in this Corporate Life Skill Advocacy Strategy

Choose between these adverts

Drink Coca Cola

Or

Drink Coca Cola.... But when the tide goes out suddenly run for high ground as it may be a Tsunami!

If Coca Cola had done this ad maybe there would be 220,000 alive and drinking Coca Cola

We as SOGON should not be too busy to examine and change our approach which has failed to bring down the maternal mortality rate in over 30 years. We should not be too afraid to speak out. Indeed we have a moral and heavy social responsibility that transcends Government General Orders for silence or acquiescence with political government and media negligence. Why do we allow some people to get away with murder by proxy..... through our own hands????? If they do not care should we join them in carelessness??? We are not at war but many at war have better services than we have. Why?

Minister Grange has pointed out at a donor interface we have had huge investments but little movement in survival. What quality of care is really provided at primary health care level by LGAs, State hospitals and Federal institutions? Phototrick or real-politic? If others do not care for our women patients, should we join them???

Political Neglect is a well known cause of Maternal Mortality: Politics and the idle antics of well-heeled and self-satisfied politicians and many civil servants without the 'milk of human kindness' consume our funds, our time and our media airtime leaving so little left over to actually achieve the MDGs. Do they engage, listen to or act on the advice of medical professionals? No. If they do, why do our maternal and infant mortality statistics continue to defy improvement? We tout ourselves as being on the road to becoming one of the top twenty economies in the world. That will never happen unless we also plan now to bring our health services and education delivery into that same bracket. It is great pity that doctors are always blamed when patients die when often the guilty parties are the politicians and the civil servants denying adequate funds, manpower, material and skills. How can a state be allowed to exist with 33 doctors on the payroll and no protest?

Government & Ministries of Information and LGAs have also failed so far. They have also to spend a much greater time and much larger budget on LOCAL Advocacy Strategies (videos, jingles, documentaries, talks, 30 sec adverts, posters, public address activities, health worker outreach programmes etc) instead of merely sending out information of government activities or first lady events while shirking responsibility to educate the citizenry consistently and repeatedly on topics chosen by a public enlightenment Think Tank made up of professionals.

We fiddle while our Rome, our womanhood burns on the altar of neglect and lost dreams.

A major Government contribution would be a Law on Media Time. Let us as SOGON present to and lobby for the national assembly to enact

* A new Media Social Message Law stating that 'Every electronic media house must allocate at least one hour per day in divided 30-60 sec advert segments and 5% of every printed advert for social messages. SOGON must petition all Media Management in Nigeria, including the Media control and monitoring commissions to change policies and introduce Mother friendly 'No fee' charges for ANTI-MORTALITY MESSAGES and start serious anti-mortality education strategic programming.

'MEDUCATION' IS MISSING IN NIGERIA Medical education.

Mathematical Gynaecology:

* Ignorance = Death and Disease

* Ignorance + Information = Life

* Information = Decrease in Maternal Mortality

* Current Education RRR = Ignorance MM

* Real Education = Increased Maternal survival

* Advertising = Education in anything

* Real Education = Life skills a curriculum change throughout the education system for boys and girls

Gynaecological mathematics: DEFICIT MATHEMATICS

* How many doctors, midwives, attendants are in deficit in employment at each of the 774 LGA, 36+1 state and federal government hospitals and clinics

* Why are LGA clinics and hospitals inferior to states which are inferior to federal? Are Nigerians inferior one to the other? They pay premium for their kiosks and shops. Misplaced values and priorities.

* How many Sonicaids, Ultrasound machines, are in deficit in Nigeria's delivery

places today? 10,000? Professor Ojo would have been delighted at the use of ultrasound scanning to find missing IUCDs and missing periods yielding strange fruit sometimes. It is no longer necessary to put a second IUCD into the uterus and take an X-ray to look for every missing IUCD and we no longer have to wait for the uterus to grow to diagnose fetal health or demise, thus making diagnosis real time and saving millions of weeks of what we now would consider as wasteful waiting. But how prevalent in 2007 is good USS diagnosis?

* How many of our hospitals would qualify to deliver animals abroad? Most should be in a Hall of Shame and SOGON should think up an accreditation scheme to close poor and illegal structures.

* Are Doctors at LGA level personal doctors of the LGA Chairman or personnel of the LGA?

Professor Ojo would be very unhappy that the maternal mortality rates have not improved over the years in spite of increased number of maternity homes, midwives and specialists in the field. But who is to blame for this lack of progress and what can we do about it? Our literacy rates hover around 45-50% and this is quoted in favour of an argument that we are too ignorant or illiterate to be educated by poster and pamphlet. However there are 30m in the formal education system and the literacy rate means that in every village street and perhaps in every home there is someone who is literate and one in two or one in three persons can read. Such literate persons, NYSC and youth, can surely be persuaded to become conduits or education proxies and read and explain to the others the contents of a Safe Mother SOGON Poster or Pamphlet produced, with private Corporate support in the 50+millions in the national interest. This is cheaper in the long run than obituary posters. Children taught in school can educate their parents.

The Media: Professor Ojo did not suffer anyone not paying attention. Though the literacy rates may be low the seeing and hearing rates are 99% and SOGON can take advantage of this by using picture posters with crosses and ticks for wrong and right practices and use the airwaves through music, straight adverts, and regular updates to preach, teach and spread best practice messages throughout the population. In an under-educated and under-informed and dangerous society like Nigeria, where ignorance is deadly and easily exploited, the media must be for more than entertainment and mere information dissemination. It should be for survival information. The Ignorance Rate is 90% while the mindless music rate is also 90%. Ignorance kills and education saves lives. SOGON cannot increase the literacy rates in Nigeria. SOGON seek ways of empowering the female population directly and the male population as well to face the challenges of safe motherhood.

SOGON/Coca Cola parallels: Remember that everyone living and dead is or was aware of and has or had the opportunity to drink a Coca Cola, a drink that has no life-giving or life-enhancing medical benefits. There are probably more Coca Cola adverts than people in Nigeria and nobody, from village to villa, goes to bed without seeing at least ten Coca Cola adverts daily. How many Safe Motherhood, Do Your Sickle Cell Test, Do your Breast Exam monthly, Do your Cervical test Annually, etc adverts does any female see in a lifetime? On average nil. Would our work as SOGON be easier if the answer was more positive? How can we and should we achieve this saturation of the public space with useful social life skill messages and SOGON life saving messages rather than 'useless' strictly commercial messages? Can we marry the two together?

SOGON is yet to sufficiently broadcast or distribute The SOGON Minimum Standards

for Preventing Infant and Maternal Mortality Pamphlet for hospitals and clinics. This effort is urgently necessary to provide the ready Gold Standard reference point for minimum standards with an aim to establish maximum standards. I have deliberately left out 'missions' and 'auxiliary nurses' in the discussion so far.

'Missions' or missionary hospitals were originally from the mainstream faiths and provided and still provide good and reliable and relatively cheap, mainly maternal and child health, services. We congratulate them. However there is a new wave of murderous 'Missions' set up by faiths, groups and individuals masquerading as being 'anointed' and seeking fortunes at the expense of families susceptible to subtle religious intimidation or persuasion. These missions provide so-called prayer, prayer, more prayer and poor or minimal maternity services at the same or higher financial and life cost. These missions have little responsibility for failure apart from claiming a maternal difficulty or death is an act of God, a 'sinful patient' or failure to believe' on the part of the family or victim. Many of us in SOGON have had to pick up the pieces from such abuses and be blamed for subsequent morbidity and mortality. This is unacceptable. Indeed Governor Donald Duke closed down missions in his state because of their contribution to the deaths of his citizens. God who called for prayers also made the harvest, the hostel and the hospital and qualified staff. So let the 'Mission' pray while the patient delivers safely in hospital.

SOGON should do research and publicist this crime against our women to bring these murderers to book and demand from government closure of all of them in the interest of the Nigerian woman and MMR. It is ridiculous to have stringent NMDC led NTA covered standards for medical practitioners and no standards for so called 'missions'. The patient, ignorant or educated, is so easily

deceived by holy book-wielding missions. The issue of nurse auxiliaries is another major issue that contributes to high maternal and infant mortality. They were created by the original missions, doctors and hospitals to reduce spending on salaries for qualified nurses and sometimes to fill the gap where qualified nurses were unavailable for employment. Today many of them dress as well as and better than qualified nursing sisters and actually have been reported to open clinics and maternity homes and thus the public is deceived into giving them the same trust they give to qualified nurses and midwives with disastrous consequences during emergencies, labour, delivery and difficulty. This deception cannot continue unchecked. The cadre should be targeted by the same government which insists on nurses examinations and it should be abolished or specifically identified with a particular colour and design of uniform and with a code of conduct book of restricted functions and public Auxiliary Nurse examinations. However any certification is likely to be more abused just as the current 'specialist' clinics and maternity homes run by some doctors and midwives are misused. There is a need for dissemination of new and important information to all medical personnel. For years it was almost impossible to put a stop to the administration of intramuscular lasix for pedal oedema in pregnancy, intramuscular chloroquine to pregnant women with malaria and not giving folic acid because it was yellow and it was considered to cause neonatal jaundice. Many midwives are probably still doing these in their maternity homes and still applying 'fundal pressure'. These actions are well established as contributing to fetal demise from hypovolaemia, cardiotoxicity and hypoglycaemia, maternal anaemia and direct trauma respectively but who knows this?

SOGON should be in a position to get

compliance within its ranks and in collaborative partnership with the Midwifery bodies in order to introduce new practices quickly, eliminate bad practices and save lives. More needs to be done to bring old hands to the new methods of care. It is disgraceful that simple, not so new, aids like sonicaid are the exception rather than the rule in even the biggest maternity hospitals. Why do we like new cell phones, the internet, new cars, new homes and regular conferences and 'retreats' for ourselves but force old techniques on our trainees, students and patients on the flimsy grounds of expense and a need to rely on clinical acumen as it was when I was a student thirty years ago? How many phone cards add up to the cost of one sonicaid? When is it irresponsible not to use modern aids in reducing the Maternal Mortality Rate?

Yes, clinical acumen is good but if it was so good, no one would have bothered to invent ultrasound or the sonicaid to help the message of fetal compromise out quicker and more reproducibly. We are also allowing our politicians and civil servants to dictate the quality, the quantity and level of technology of Nigeria's maternal and child care. Our mothers and children are paying the price in the high mortality and morbidity rates. The woman Speaker's refurbishment N625m would pay for 12,000-15,000 sonicaid machines and batteries/wind up motors which could have been negotiated through SOGON to bring down the cost per unit.

Of course, it is not all about having equipment as equipment is useless if there is not battery or electricity or will or experience to use it. We all remember how difficult it was to introduce the active management of labour and the partogram. There is a need for personal integrity, skill and will and also a need to think out of the box and be receptive to new ways of doing old things.

There is a need for questions and change where necessary. Professions do not grow without questions and the search for answers. We were and probably still are taught to examine with the Pinard stethoscope between contractions starting as much as one minute after the contraction is over to allow for 'recovery'. But everyone in this room knows that if you really want to know how close the baby is to death you should listen during and immediately after the contraction and listen for and count the lowest heart rates and the recovery time. That will give you a real time cardiotochographic impression without the cardiotochograph and is very useful for detecting cord around the neck. By the time the inter-contraction Pinard stethoscope has given you bradycardia and 'fetal distress' you are in need of serious resuscitation for the baby and may even lose it thus increasing perinatal mortality. Getting in early saves medical costs, input and lives. We should distinguish between the C/S rate and the successful live birth C/S rate.

But if our students say this in an exam will they become SOGON members?

What is our SOGON Statement on Maternity Leave at this time of abuse of woman's working rights? Is it woman and child friendly enough? Has it been revised recently? Is it still the old 'six weeks before and six weeks after' delivery and lose some if you deliver early or late? Long ago we fought for and won 'three consolidated months from whenever the patient starts'. Should we be pushing for four or six months? Should we not entrench maternity as a national service and to be accompanied by full pay? After all, the patient does not eat half rations for half of the leave and in fact spends more during the second half of the leave. The full weight of SOGON in conference can be brought to the support of women organizations and the Minister of Health meeting the national assembly and

the presidency on this matter.

To help save our women also consider.....

1. The introduction of a National Medical Discharge Summary Law: This will make it mandatory that every single patient admitted to any medical facility or clinic as an outpatient must have a NMDS to inform them of what was done and the diagnosis. This will empower the patient and help prevent exploitation. It should especially be applied to all clinics and nursing homes assuming that 'missions' have been closed. There must be much better quicker reporting of maternal and infant morbidity and mortality at LGA, State and Federal levels with quicker monthly release of statistics, to locate poor care spots. With neighbourhood computers everywhere it seems possible to establish a SOGON led National Maternal Mortality/Morbidity Database. This could conveniently plug into the WHO's recently launched Health Metrics Network CD for a comprehensive register of births and deaths worldwide.

2. SOGON Accreditation Guidelines and Certification should be a sought after standard of practice and facilities assessment. Perhaps we should invite the respected SON to partner with SOGON/NMA in establishing measurable standards of facilities. This would be a powerful bargaining tool to gain improvements in funding from politicians and civil servants busy reducing health budgets. Certainly a threat of 'failure to meet international or local SOGON/NMA/SON Standards' would be a real and immediate threat to almost all our medical institutions and a huge bargaining chip for our highly skilled professionals trapped in such institutions and silenced by the Go General orders from protesting anti-maternal mortality strategies of government agents. Standards are not a secret. Standards are everyone's business and responsibility. Too often our patients have suffered in poor facilities created by the power of non-medical supervising

authorities. This must stop and The NMA should also be considering NMA Accreditation.

3. Free maternal and child health services are good anti-maternal mortality strategies and a smart political and media mantra but such slogans send a shudder of angry disappointment through SOGON members. It must be more than a slogan and idle boast because women and their husbands are quick to believe that such statements mean 'bring nothing' to hospital and have come to grief as a result in the past. 'Free' must never again mean 'No Health, No drugs, no beds, no equipment, no gloves, no nothing' and the even worse 'Do not ask the patient for anything or agree that anything is lacking'. 'Free' must mean 'Free, Fully Funded, Family Supplemented' and be backed up with adequate numbers of support products and funds. No free health programme should reject family contributions and should actively encourage them in a Public-Patient-Partnership. Such grand programmes must be independently monitored by SOGON as it is the SOGON members who will have the difficulties of delivering patients without wearing gloves, doing Caesarian Sections with torches and without appropriate stitches, needles or anaesthesia, repairing episiotomies without local anaesthesia and have three patients to a bed as we all have done in the bad old days of past 'free health'. Silence will kill our mothers. 'Out of stock' must never again be allowed to become the nightmare stock answer to request for surgical gloves, antibiotics, ergometrine, oxytocin and of course prostaglandins are out of the question. A commissioner of health once told me that the patients should be given panadol instead of writing 'O/S' because they are ignorant. Indeed SOGON should put out its own SOGON Budgetary Analysis & Hospital Needs List/patient/procedure Guidelines needed to meet the expected demand and calculate estimates for money, material and bed

spaces to cater for the mothers who will flood the hospitals. There must be no disconnect between patient load and supply of support services. Thirty patients require thirty times the support facilities and drugs that one patient needs. This multiplier effect is simple to budget, plan and monitor for corruption, incompetence or negligence.

4. Budgetary Considerations: New Medical Indices to curb under-funding during free health programmes by unscrupulous government agencies must be introduced and taught in medical and other schools.

Budget projections and extra budgetary allocations based on calculation dependent on number of patients expected for a particular procedure. Units of cost excluding what should patient bring e.g. pads, personal sanitary items and baby's personal items.

1. ANC cost including lab tests, / visit times eight visits per patient NXXX
2. Spontaneous Abortion treatment costs/patient NYYY
3. Sickness in pregnancy e.g. malaria/anaemia/HIV-AIDS cost per patient NZZZ
4. SV Delivery cost per patient (excluding salaries) NNAAA
5. Assisted delivery cost per patient N BBB
6. Caesarian Section cost per patient including antibiotics and eight day stay NCCC
7. Baby care per day
8. Incubator cost per day
9. Ectopics/cysts and other similar surgery per patient
10. Miscellaneous treatments
11. Ultrasound/X-rays/Blood tests/ @ four each per patient
12. Blood transfusion @ 1 pint per 2 patients

By multiplying these figures by the past and expected number of patients in each category it will be easy to allocate adequate funds in each hospital's budget and just as

importantly for SOGON or other agencies to monitor compliance by government agencies in attempts to reduce MMRs. For spontaneous abortions a rough calculation can be x 10% of ANC patients.

Thus anyone with a brain will be able to calculate what a hospital with a delivery rate of 1000 and a C/S rate of 20% or 200 and a spontaneous abortion rate of 10% or 100 should have as a monthly allocation to meet the needs of a Free health programmers and be able to raise an alarm to the relevant authorities and more importantly to the public assuming that that is not a breach of the GO.

SOGON should engage governments in negotiations to this end and move to get agreement and also monitor that governments at Federal and State level should pay a fee per patient in advance so that the hospital is constantly able to service the patient needs and the medical staff's requirements for the care of the patient. You cannot treat a patient with arrears of allocations.

5. Free health should include a large Free Access to the Media for SOGON/NMA health messages.

6. Pay attention to patient friendliness: Medical Cleanliness especially ward and clinic regular painting even with whitewash. TLC = Toilets, Laboratories, Clinics

7. SOGON needs the regular TV and radio appearance of a recognizable public face or faces with life skill messages *a la Dora Akunyili* who by the way should be honoured by SOGON for the work of NAFDAC in saving the lives of our women and children through an active structured advertising campaign. SOGON should have a SOGON National Maternal Mortality Media Enlightenment Campaign too with a series of TV and radio SOGON Statements of Fact to Change Your Life.

8. SOGON Prize for Best Social Messages on TV, Radio.

9. SOGON should have a SOGON National

Maternal Mortality Poster Enlightenment Campaign and produce 10 posters covering key issues in 20 millions with support of Corporate Nigeria.

10. SOGON Second Opinion Hotline/Clinic on internet/telephone and a physical structure for professionals and patients and relations and run by senior professionals, perhaps retired. Cell phone companies can be persuaded to participate as a service.

11. A major drawback to quick health delivery is the lack of pathology support histology and hormonal assays. This should be monitored as part of an Annual Monitoring Report. Solutions must be found. A six to twelve month wait for a histology report borders on the criminal. Some honest sorting and Histology Specimen Ranking needs to be done for ordinary patient specimens who cannot afford private pathology fees. Suspected Cancer specimens can be ranked as A, i.e. most urgent while others are B, C, D etc. A year ago a patient had a recommended biopsy specimen of an ultrasound diagnosed breast cyst delayed and finally lost. During that year she was denied access to the specialist doctor because 'her test was not ready'. She now has obvious extensive carcinoma of the breast. Who will be held responsible for this woman's complications? The pathology department, the pathologist, the nurse organizing the clinic or the system? The patient did everything correctly. We need a new SOGON/Pathology Guideline, systems check and systems change in regard to histopathology and hormonal assay specimens and a vastly improved turn around time for pathology specimens.

12. Every hospital needs a Hospital Ombudsperson to mentor, monitor, guide and cut through damaging red tape in the interest of the patient threatening to fall through the gaps and to guarantee best medical practice. Such a hospital ombudsperson could be a much loved retired member of staff, well liked and well

known and respected.

13. Time and Motion studies for all stages of patient-treatment/specimen analysis/quality of service times are needed. Internal and external medical audits are needed to improve standards. Time and motion studies in terms of how difficult it is to get service to and for patients-time wasted in 'effort' like walking between services or between payment points or in the endless and too numerous queues. Turn around time for specimens What is the arrival-diagnosis interval? What is the diagnosis-treatment interval for ectopic pregnancy for example? Quality control tests for service, facilities and laboratory tests.

European corruption does not compromise services, standards or quality. African corruption cripples the country, services, quality and standards. It is always possible to practice good honest medicine even if those around you do not.

We must embrace, metaphorically speaking the midwives

Every message SOGON sends to the public will save 100, 1000, 10,000 lives? Every message SOGON does not send to the public will cost 100, 1000, 10,000 lives? Who will dare continue to carry that responsibility?

Professor Ojo had other talents besides medicine as do most other members of SOGON some of whom would jump at the chance to develop life-skill advert material for the media. It will be worth while employing or recruiting as a volunteer an advertising guru-funded by a woman friendly corporate sponsor Oceanic Bank springs to mind.

Harden not your arteries with bad food, lack of exercise and Lethal, LDH, Fat.

The battle against maternal mortality is not a SOGON battle. The Maternal Mortality and Infant Mortality Rates are not a disgrace to SOGON. They are disgrace to every Nigerian

professional, politician and political office holder past and present. A doctor is only as good as the tools he is given. All the OB/GYNs abroad cannot reduce the Maternal Mortality Rate in Nigeria without facilities...

We are fond of throwing up lists of causes of Maternal Mortality which have not much changed over the last fifty years so who do we bother if we are not going to get action on them? The items missing from the list are the most important.

1. Incompetence
2. Ignorant
3. Corruption
4. Poor skills
5. No supervision
6. no punishments are often absent Add
7. Late referrals Low Apgar Scores
8. Dead referrals Zero Apgar Scores
9. Immunity i.e. No investigation/poor feedback to referral source
10. Inadequate quantities of posters and material to cover the millions of target citizens students, traders, religious houses.
- 11.

We must take a lesson from the Soludo Solution to the failed naira and also seek to move the Intervention Alert Line two decimal places to the left to reduce the maternal mortality by acting earlier. But we must do it by hard work. Maternal mortality rates cannot be reduced by fiat from the federal and state government. We have become immune to deaths which in other countries would cause a revolt. We must become more aggressive, more proactive, more committed to saving that unborn baby's life at a higher birth Apgar Score a sacred right and the life of the baby's mother. Doctors and midwives cannot do it alone. Everyone had a mother and should be involved and should contribute to reducing MMR.

What is your EDD may be changed to DDD Dangerous Delivery Date, or Deliver Day

Danger and that is not the least bit alarmist as the WHO has pointed out. Surely fdLMP is better than LMP?

International Advertising Private Public Partnerships: In order to improve the fate of mothers beyond Nigeria's borders, in Africa and elsewhere where billion dollar commercial adverts predominate in the media, SOGON should carry this need for the Corporate worldwide to give part of every advert up for 'Life Skill Social Messages' in piggyback messages to the WHO, UN, Global Fund etc and encourage 'International Advertising Private Public Partnerships'.

In summary we at SOGON must individually and collectively get Government, Corporate Nigeria and the Media to explore their options and fulfill their responsibilities and opportunities to positively impact on the health and lives of our women from an early age to help guarantee them maximum educational, health and medical support during pregnancy and delivery the most dangerous Day in their lives. SOGON must MMR Monitor Maternal Mortality Rates. It is easy to criticize the hard work of others. This lecture seeks only to add to the laurels already crowing SOGON with success under fire and difficult circumstances. The lecture is to help recruit billions of naira in good will and in reality and also millions of adverts and media hours to the battlefield of MMR and the achievement of the MDGs. Every dead mother is one too many and a bereaved family.

Let us end by acknowledging the efforts of our founding fathers, Professor Ojo prominent among them, and SOGON executive and members past and present and our examiners. Let us applaud them and encourage them to greater heights and encourage all of us to more government, corporate and media cooperative and innovative strategies to lower Nigeria's high mortality rates. Long live the Nigerian

mother and child. Long live SOGON.

Quick Reference Summary for SOGON led MMR reduction strategies

1. Annual SOGON State of the Nation's Girl & Maternal Health' Report
2. Set up SOGON/SON Accreditation Guidelines
3. Canvas increased allocation to Health Advocacy budgets at all levels
4. Encourage modern equipment aids/techniques/to reduce MMR
5. Monitor Post Graduate Programmes more closely
6. Use lobbyists to introduce the National Medical Discharge Summary Law
7. Use lobbyists at the State and National level to introduce the National 'Social Message Media Law' that 60 minutes daily in divided segments of 30-60 secs must be available for free social service advertising of a life-skill nature'
8. Set up a SOGON Prize for O & G Creativity
9. Monitor 'Free' Maternal services nationwide
10. SOGON Top 20 Social Messages given to the media annually
11. Design or recruit SOGON Education Poster Series/Prizes on all thematic areas affecting girls and women and invite Corporate funding for millions of copies
12. Design or recruit SOGON Educational 60 sec, 30 sec Adverts/Prizes on all thematic areas affecting girls and women to reduce morbidity and mortality.
13. Recruit Corporate Giants benefiting from female products into partnerships to choose and fund any of the SOGON posters in the millions for joint distribution throughout the country to target schools, teachers, kiosks, shops,

markets, etc

14. Recruit Corporate Giants benefiting from female products to choose and fund any of the SOGON Adverts across the media to target girls and women and boys and men
 15. Recruit Corporate Nigeria to add a piggyback, dual message 'life skill message' to their adverts, T shirts, posters
 16. SOGON must develop its 'Academic Committee' to be proactive in advances and correcting bad old habits in a SOGON newsletter on line and in hard copy
 17. SOGON must develop its 'Public Relations' to include Public Outreach Projects with a budget, corporate supported, capable of making an impact through the media
 18. Lobby for and obtain satisfactory and realistic budgetary provisions for maternal and neonatal health
 19. Support the lobby for a National Youth Centre Scheme one per ward where SOGON health and other education visual material can be displayed year on year, day on day to community youth. Such Youth Centres can be supervised by NYSC members
 20. Motivate the Federal and State and LGA Ministries/Departments of Information to take on a serious preventive health role nationwide and in Local Languages to reduce maternal morbidity and mortality.
- SOGON should promote 'International Advertising Private Public Partnerships' in Africa and elsewhere and get the Corporate world to get piggyback 'Life skill Messages' strategies promoted by FIGO, WHO, UN, Global Fund etc.