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SBCC: A STRATEGIC APPROACH TO REDUCING MATERNAL MORTALITY IN COMMUNITIES IN CROSS RIVER STATE, NIGERIA

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ABSTRACT

Maternal mortality is still a high risk for women of childbearing age in Nigeria raising from 14% in 2003 to 19% in 2019 (Meh et al., 2019). Ope (2020) reported a rise in maternal mortality of 814 per 100,000 live birth in Nigeria. A situation a slight rise in the maternal mortality rate in the country contrary to the view earlier held that maternal mortality was on the decline (WHO, 2019). This review is developed in line with the WHO report that shows that maternal mortality has suddenly rise again in Nigeria. The study was conducted to explain the role that social behaviour change communication (SBCC) ca n play in the reduction of the maternal mortality in Nigeria. The review involved scoping of literatures and identification of seventy-one 971) articles, whose content were read and arranged in themes comprising; maternal mortality and trends in Nigeria, causes and factors promoting maternal mortality, Sustainable development goals (SDGs) target related to maternal mortality, SBCC as the such techniques to address maternal mortality in Nigeria and challenges hindering the reduction of maternal mortality in Nigeria. The intention of the paper is to proffer SBCC as a locally acceptable strategy that can address the rising and falling status of maternal mortality in Nigeria. Finding from the review show that SBCC have been used in different countries to address several health related issues and by Non-governmental organisation in Nigeria as well making it a potent strategy to address the issue. It is recommended that SBCC as a simple strategy that involve enter-educate strategies targeting different component of the communities including gatekeepers is an effective and efficient approach in reducing maternal mortality at all level. It implies that if carefully planned and executed, the issue of maternal mortality rise in Nigeria will be quickly reduced to the barest minimum if not totally eliminated in Nigeria in the near future.

KEYWORDS: SBCC, Maternal Mortality, Strategic Approach, Nigeria

INTRODUCTION

The sex ratio signifying the proportion of female population in the world in 2017 shows that the population of women globally was 49.6% of the entire population (Ritchie & Roser, 2019). With the world population as at 2020 put at over seven (7) billion, females proportion was 3,865 billion representing 49.58% with the Total Fertility rate (TFR) put at 2.5 live birth per woman (United Nations, 2021).

Reproductive Health is defined as “a state of complete physical, mental, spiritual and social wellbeing and not merely devoid of disease or infirmity, in every matters that has to do with the reproductive system and its functions and processes” (Yar’zever, 2014; Ogu & Ephraim-Emmanuel, 2018)). There is high rate of maternal deaths in many developing countries across the world and most that is, 34 percent of the maternal death occur in Nigeria and India (Ope, 2020). Also, it is affirmed by Pathfinder Internaltional that India and Nigeria accounted for one-third of global maternal mortality ratio (Pathfinder International, 2021). Similarly, the World Bank Group (2021) reveal that in 2017 the top five

countries with the highest maternal death were in African in this order South Sudan (1150/100,000 live births); Chad (1140/100000 live births); Sierra Leone (1120/100,000 live births); Nigeria (917/100,000 live births) and Central African Republic nad Somalia have (829/100,000 live Births) in the world (World Bank group, 2021). This is not different from the assertion of Pathfinder Internationals that stated that more than half of all maternal mortality happen in just nine nations especially in Africa with Nigeria being one of the leading nation every year (Pathfinder International, 2021).

Whereas, WHO (2019) posits that 303,000 women die from pregnancy related complications annually (WHO, 2019); Pathfinder International on the other hand presented a statistic indicating that 99% of global maternal mortality deaths take place in third-world countries (Pathfinder International, 2021). Maternal Health is an important aspect with huge global and economic significance in the life of individuals. The health of women of childbearing age in the time of pregnancy, when delivering a child and six weeks after delivery is important to promote adequate wellbeing of the home and family, especially in issues that has to do with childbirth, childcare, home care, breastfeeding and several other important aspects (Ogu & Ephraim-Emmanuel, 2018). Nigeria has invested a lot of effort through the government and partners at all level towards maternal mortality reduction in line with international standards including Federal and State governments implementing free antenatal services, training of Skilled Birth Attendants, engagement of TBAs/FBAs as well as resources put in, yet the situation seems not to be improving at the rate that will be appreciated as the 814 per 100,000 live births put forward by WHO is still very high and not indicating good progress with Nigeria having one of the highest maternal death in Africa (Ogu & Eprhaim-Emmanuel, 2018; WHO, 2019). The Minister of Health in 2017 during the inauguration of the 34-member Task force to accelerate reduction in Maternal deaths in Nigeria statement was that "Maternal mortality remains unacceptably high in Nigeria, ranking among the highest in the world and the rate of reducing this death has been slow because several of the factors contributing to this matter of serious Public Health concern has remain unaddressed… (WHO, 2018). This affirmed the fact that there has been slow progress in finding lasting solution to the issue of maternal mortality.

One of the key problem that can be seen to be responsible for the continue high mortality rate that has also embolden other causes is the case of poor service availability, uptake and delivery services as well as poor implementation of policies at all level (Ogu & Eprhaim-Emmanuel, 2018). Aside the prevailing cause already outline above; late registrations, poor attendance of ANC, poverty, illiteracy, low knowledge, delay in getting to the health facility on time, bad roads, poor communication networks, poor transportation system and transportation arrangement and time wasting in receiving the needed care at health facilities that give rise to poor quality maternal health services, insufficient number of Skilled Birth Attendants, insufficient supplies of medical commodities and equipment during labour, delivery and post-natal, poor uptake of pre and post Modern Family methods, COVID-19 protocols observation and EndSARs Crises are other causes that is contributing to the high maternal deaths in the Cross River State (Uzoigwe, 2016, WHO 2020).

The global concern for maternal death can be traced back the safe motherhood conference in 1987 that was held in Nairobi, Kenya. During the conference, there was a call for reduction in maternal mortality across the world especially in developing nations. It was the outcome of this conference that gave rise to the Millennium Development Goals (MDGs) declaration with some of the targets set to improve maternal health and reduction of maternal mortality (Anger, 2013; Eto, 2016). The MDGs have already been replaced by SDGs also aiming to ensure maternal mortality is brought to the barest minimum. In the light of the outcomes identified, serous attention must be paid to tackling the maternal mortality challenge that is before most third world countries that has in turn affected the ability of pregnant women to register early for antenatal care services, register and continue ANC in facilities as well as access timely quality maternal health care

services all intended to contribute in causing a reduction in maternal mortality in South-South, Nigeria (Uzoigwe, 2016; Ogu & Ephraim-Emmanuel, 2018). This study is therefore design to examine the role that SBCC plus entertainment education strategies can play in the reduction of maternal mortality and prevention of PMTCT in Cross River State, Nigeria.

METHODOLOGY

Evidence gathering and literature selection:

Three components constituted the evidence gathering including:

a. **Searching of Databases:** This was done for certain topic or fields in the area of health, social sciences and sociology. For health PubMed was search. Peradventure the results gotten are not enough, the search sensitivity was maximized by reducing the search items.

b. Hand Search: Data for this review was conducted through hand scoping of relevant literature to identify studies that discuss "Social Behaviour Change Communication and maternal mortality in Cross River State, Nigeria". Journal and websites were hand-search and included;BMC women's health, BMC Pregnancy Childbirth, BJOG, PloS One, Google Scholar, Journal of advances in medicine and medical research, journal of Global Health report, Clinical Journal of medicine, African Journal Reproductive health, International Journal of Gynaecology Obstetric, WHO Library, World Bank Websites and Nigeria Government Ministries, Departments and Agencies (MDA), Websites and reports of Non-governmental organisations (NGOs)/Foundations and University websites. Peer Reviewed literature was also search to supplement the official document and grey literature search.

c. Reference Search: References of the articles and papers that meet the eligibility criteria was also search by hand to identify more references that will be screened and selected to be part of review.

RESEARCH DESIGN

Every study/research designs (Quantitative, Qualitative, mixed methods and systematic researches) that were eligible as well as journals were also included in the study.

Types of Interventions

This review looked out for studies that discuss SBCC and maternal mortality in Nigeria and globally be it, trends, causes and factors promoting maternal mortality in Nigeria, SDG related to Maternal mortality, policies and dialogues as well as challenges.

The Keywords

used for search were, "maternal mortality prevalence", "SBCC", "Strategic approach", "Nigeria", "SDGs" and "communities".

Inclusion Criteria

Only papers review that is written in English language were included in the review and searches was restricted to studies between year 1999 to 2022.

Exclusion Criteria

Editorials and popular media was excluded. Also, studies not reported in English language or was done earlier than the

year 1999 in the subject area were excluded.

Seventy-one (71) articles met the selection criteria and where included in the study. At the end of the review the selected articles were reviewed and were arranged into themes presented in the review.

MATERNAL MORTALITY AND TRENDS IN NIGERIA

Maternal mortality as define by UNICEF is the death of a pregnant woman as a result of complications resulting from pregnancy or when giving birth to child (UNICEF 2021). The maternal Mortality ratio (MMR) on the other hand is explained to be the number pregnancy-related death recorded amongst women/girls who are pregnant, during delivery and 42 days after terminating a pregnancy per 100,000 live births (Macrotrends, 2021). Knoema.com definition of MMR is not different from the above, the only different is that it did not add the aspect that a pregnant woman could still die 42 days after giving birth or having an abortion (Knoema.com, 2021). MMR has continued to take the lives of numerous mothers in the world and several nations are still struggling to reduce it (Sule et al., 2021).

Sub-Saharan Africa where over 50% of all maternal mortality cases takes place, have experience stagnation. Nigeria is one of the country that maternal death has been hugely reported as a key Public Health Issues especially in northern Nigeria. Maternal mortality is still a high risk for women of childbearing age in Nigeria raising from 14% in 2003 to 19% in 2019(Meh et al., 2019). Nigeria occupies the second spot among countries with high maternal mortality ratio, only second to India before 2015, but by 2017 ranking Nigeria was the highest with 917/100,0000 live births against India's 145/100,000 live births (Todo, 2020; Macrotrends, 2021).

Knoema reported 917 deaths per 100,000 live births in Nigeria which was supported by IndexMundi 2017. However, like the WHO (2019), Abeshi reported that in 2015 the maternal deaths were 814/100,0000 live births (Abeshi, 2017). The trend of maternal deaths in Nigeria has continued to go up and down (Table 1).

CAUSES OF MATERNAL MORTALITY

Maternal deaths are as a result of several underlying causes that will be briefly considered in this sections. They cause of the high maternal deaths in Nigeria is as follows:

a. Inequities in Health Services: There is high level of inequalities of health services in Nigeria especially in the rural areas. The consequences of inequity and inequality is worrisome. The World Health Organisation (WHO) asserts that the increase in the number of maternal death across the world is a reflection of inequities in access to healthcare services (WHO, 2021). The report further revealed that almost 100% of deaths due to pregnancy or child delivery happens in developing countries with over half of it taking place in Sub-Saharan Africa and South Asia nations (WHO, 2021). This is said to be as a result in the wide disparity in health inequity between the rich and the poor, as well as the urban and rural dwellers in Nigeria.

Table 1: Trend of Maternal Mortality Ratio From 2008 to 2019

S/N	Year	Per 100,000 Live Births
1.	2019	814
2.	2017	917
3.	2016	925
4.	2015	931
5.	2014	943
6.	2013	951
7.	2012	963
8.	2011	972
9.	2010	978
10.	2009	987
11.	2008	996

In the United State for instance, severe complications of pregnancy and maternal deaths are rare (Murray, 2019). which is contrary to what can be said about Nigeria with a continuous rise in maternal death and poor budget for health over the years. Until inequity and inequality is addressed in Nigeria with resources evenly distributed at least (equality) or those at disadvantage given more resources to balance what those at advantage position have (equity), then achieving the desire of bringing maternal death down to the required percentage by 2030 will continue to be an herculan task (WHO, 2021).

b. Haemorrhage: Sub-Saharan Africa nations including Nigeria, reports show that haemorrhage is the leading cause of maternal mortality globally as well as in Nigeria (Fawole, Shah, Fabanwo, Adegbola, Adewunmi, Eniayewun et al. 2012). In a study conducted by the WHO, postpartum haemorrhage – that is excessive loss of blood or bleeding after child birth was confirmed to be responsible for 27% of deaths of pregnant women (Murray, 2019). With severe amount of bleeding as a result of haemorrhage, the mother's internal organs could go into shock due to poor blood flow which is fatal, or leading to intravascular coagulation. In a study in Ogun State, Nigeria, it was revealed that haemorrhage accounted for 36% of maternal deaths, while in another study in Jos, Nigeria, haemorrhage caused 34.6% maternal deaths (Sageer, Kongnyuy, Adebimpe, Omosehin, Ogunsola & Sanni, 2019).

c. Eclampsia or High Blood Pressure: Eclampsia is considered as a complication of preeclamsia (Miller 2013). It is defined as the onset of convulsions described as the grand mal-type of seizure that first appear before or during labour and 48 hours from delivery and/or coma related to other cerebral conditions in women with preeclampsia symptoms. Eclampsia is affirmed by Murray to be the second leading cause of maternal mortality and is due to high blood pressure and protein in the urine. Hypertensive disorder is responsible for 14% of pregnancyirelated deaths (Murray, 2019). Findings in a study conducted at Mater Misericordiae Hospital Afikpo, a rural Secondary cum referral Catholic Mission Hospital, Ebonyi State, Nigeria revealed that for every 89 women that delivered in the hospital, there was at least one case of eclampsia (Esike, Chukwuemeka et al., 2017). This affirm the fact that there is almost 15% death due to eclampsia in developing countries like Nigeria. Risk factors for eclampsia included, family history, multifetal gestation, patient older than 35 years, teenage pregnancies, lower socioeconomic class, obesity and so on (Chulmi & Sibai, 2012).

High income nations have been able to bring a decrease in both the incidence and case fatality rates associated

with eclampsia by about 90% using a combination of early detection during antenatal care and increase in the number of women that access and stay with skilled health facilities for care (Goldenberg, McClure, Macguire, Kamorth & Jobe, 2011). This is not the case in developing countries with above 50,000 deaths yearly due to maternal death most from eclampsia (Rabiu, Adewunmi, Ohun, Akinlusi, Adebanjo & Alausa, 2018). In another study in Lagos State University Teaching Hospital (LASUTH) indicated that 99% of eclampsia cases occur after 28 weeks' gestation (Odelola, Akadri, Akinpelu, Elegbed, Ogunyemi & Popoola, 2020).

d. Sepsis/Infection: Another cause of maternal death is the presence of us-forming bacteria or their toxins in the blood or tissue. Every person has their unique immune system, and when a woman is pregnant, their immune system is lowered, making them vulnerable to infections and sepsis (Leveno & James, 2013). Some of those infections included, amniotic fluid and surrounding tissues, influenza, Genital Tract Infections, fever, chills, abnormal heart rate and breathing rate are indicative of infection. Sageer et al findings outlines sepsis as one of the cause of 5.7% of maternal deaths in Ogun State, Nigeria. Another study specifically shows Puerperal Sepsis as the third leading cause of death amongs pregnant women after eclampsia and haemorrhage accounting for 12% maternal deaths (Okwudili, Oluwaseun & Esther, 2020). In Northern Nigeria puerperal Sesis accounted for 19% of maternal deaths (Okwudili et al., 2020). In another study, 15.4% of respondents affirmed that sepsis was one of the leading cause of death. Late complications can also result from puerperal sepsis including infertility, ectopic pregnancy and intestinal obstruction which could lead to morbidity and mortality (Guerrier, Oluyide, Keramarou & Grais, 2013).

e. Unsafe Abortion: It is estimated that 7.9% of all maternal deaths were as a result of abortion, including spontaneous or induced abortion and ectopic pregnancy (Say et al. 2014). However, in a research in Jos, Nigeria 9.4% respondents mentioned abortion as one of the direct cause of maternal mortality (Ujah, 2005). With increase in sexual activities across all ages for women of childbearing age, the number of unintended and unwanted pregnancy has also increased and the outcome is increase in the number of abortion adding to maternal death(Akpanekpo, Umoessien & Frank, 2017). One factor responsible for high rate of abortion is the low use of modern contraceptives for family planning. Akpanekpo and co-researchers supported the fact that unsafe abortion is a common cause of death among pregnant women and other women of reproductive age. The high level of stigmatisation associated with abortion in Nigeria is also a contributory factor for the continuous rise in maternal death, because abortion is only legal to save a woman's life, so many hide to do it with quacks to avert the same of being label as having a child out of wedlock (Bells, Omoluabi, OlaOlorun, Shankar & Moreau, 2019). In 2012, there was 33 abortions per 1000 women aged 15-49 years; this increased to 45.8 abortions per 1000 women of childbearing age of which two-third were unsafe (Bell et al., 2019). Abortion is a Public Health concern in Nigeria as it is common and unsafe due to health inequity. Unsafe abortion is the reason why about 500,000 women experience serious health challenges, and 212,000 receive treatments for complications contributing significantly to high proportion of maternal deaths in Nigeria (Akande, Adenuga, Ejdike & Olufosoye 2020). Latt, Milner and Kavanagh brand it as the commonest cause of maternal death and higher in country like Nigeria especially in Cross River and Akwa Ibom State with high teenage pregnancy in the South-South region (Latt, Milner & Kavanagh, 2019).

Other Causes of maternal death in Nigeria includes malaria in pregnancy, congestive cardiac, anaemia, Pneumonia and heart failure (Payne, 2016; Agan, Monjok, Akpan, Omoronyia & Ekabua, 2018). In addition, isues such as Domestic Violence, HIV/AIDS, and depression also contributes significantlt to maternal death in Nigeria (Filippi, Chou, Ronsmans, Graham & Say, 2016). In fact, Murray said indirect causes of maternal deaths is put at 9.6% which is considerably high and until this is address, Nigeria may continue to find it challenging to address issues of maternal death (Murray, 2019).

FACTORS PROMOTING MATERNAL MORTALITY IN NIGERIA

Some of the factors that contributes to the high number of maternal death in Nigeria are as follows:

i. Age: There is a common parlance that age is just a number, but not in the case of reproduction and maternal health. Age is a key contributory determinant of maternal death. Women in their twenties are likely to have little complications during pregnancy and child delivery than those below that age category and those above the age category (Murray, 2019). Girls younger than 15 years are more likely to have complications during pregnancy and childbirth leading to death, which is also applicable to those in their late 30s, 40s and 50s (Murray, 2019). In a study in four districts in Bangladesh, it was discovered that younger or older age women had higher risk of losing their lives during pregnancy or during delivery than those in their twenties which corroborate with the assertion of Murray (Halim, Biswasj, Rahman & Brock, 2014). The WHO report was not different from what has been posited by the two researchers as they confirmed that there is a probability that there will be 1 in 45 maternal deaths cases in Nigeria than what is obtainable in other country which is 1 in 5400 cases (WHO, 2019).

ii. Socioeconomic Status: This is one risky determinant of maternal mortality in Nigeria (Jeong, Jang, Park & Nam, 2020). The socioeconomic inequities in basic maternal health interventions exist in some countries like Egypt and Nigeria, yet very little is known about the health-seeking behaviours of poor households (Benov, Campbell, Sholkamy & Ploubidis, 2014). In Nigeria, the standard of living such as household income which is the yardstick for measuring socioeconomic factors has major effect on maternal deaths (Hamal, Dieleman, Brouwere & Cock-Buning, 2020). With Nigeria now the capital of poverty in the globe and with skyrocketing inflation rates, implies that families cannot afford keeping money to offset healthcare cost when they have not even seen what to eat. For example, which poor household can afford the cost of visiting the facility monthly or bi-monthly for check-up and ANC, not to talk of paying for delivery or Caeserean Section cost in Cross River State, Nigeria with the highest unemployment rate in Nigeria? This answer is very few in favour of couples with poor reception and treatment gotten from healthcare facilities, that is why TBAs and Faith Birth Attendants (FBAs) will continue to flourish and maternal mortality continue to rise. In the Third world countries like Nigeria, the risk of a woman dying during pregnancy of childbirth is 100 times higher than in the developed world (Jeong et al., 2020). There is a strong correlation between households' income level, education and occupation with maternal mortality. Poor women in lower socioeconomic group may have less education, poor diets and barriers to healthcare than rich women and it is not hidden that less education contributes to an earlier unplanned pregnancy. Lack of good nutrition leads to health deficiencies and por pregnancy outcomes (Murray, 2019). Not getting quality care exposes women to the risk of contracting infections and other complications that could be otherwise taken care of if they women were able to afford cost for treatment/care by skilled health workers (Murray, 2019).

iii. Gender Inequality: Nigeria is largely a patriachal society, men are usually heads of housholds and act as gatekeepers (Yaya, Okonofua, Ntoimo, Udenige & Bishwajit, 2019). Murray Opined that girls and women in some countries are often denied financial resources, work, empowerment and do not have a say in their own lives and family choices (Murray, 2019). The United Nations has called for human right-based approach to maternal healthcare that makes it available, accessible, acceptable and affordable to all women whether in rural or urban setting (Yaya et al., 2019). There is large gender imbalance in Nigeria and gender inequality do not give women access to quality healthcare which would have averted most of the maternal deaths recorded. Some studies have identified gender as a determinant of maternal mortality. Gender dynamics and intersections impacts maternal access and uptake of health services like ANC which approval must be given by the husband even at the point of death which could result in death (Yaya et al., 2019). Gender norms are

embedded in socio-cultural practices and persist leading to most maternal mortality (Oduenyi et al., 2021) Intra-household power structure, gender dynamics of resource allocation and women's limited ability to participate in decision-making can have a huge impact on maternal health-seeking behaviour that could eventually result in maternal death (Yaya et al. 2019).

iv. Late Registration and Poor Attendance to Antenatal Care: Two key factors have been identified to be responsible for the rise in maternal deaths, that is; late registration for ANC and going away to deliver with TBAs after registering with health facilities (Ope, 2020). For many Pregnant women in Nigeria, receiving quality ANC services from qualified, skilled and motivated health workers is important. However, getting access to these quality services for women of childbearing age is difficult especially for those in the rural areas, that even with PHCs present have acute shortage of qualified and skilled workers (WHO 2020). It was added that poor attitude and unprofessionalism of most of this health workers while attending to pregnant women, treating them with much disdain is reasons why most pf the pregnant women will continue to patronise TBAs and FBAs in their community at the instance of health facilities WHO, 2020). Most of the health facilities are not even well equipped to handle maternal health care services. The distance to some is too far making it difficult for pregnant women to travel hat far. There is also issues of, not being affordable, poor information and lack of trainining/re-training for health staff that has continued to push pregnant women away (Iruoma, 2021). Also, in the facilities there is a lot of time wastage and this influence women decision to register and stay with the health facilities for their ANC needs and delivery because they are so motivated to continue being treated with respect by facility staff and this push them to TBAs/FBAs who may not refer them on time to facilities when there is delay in labour for over six hours or serious complications and this has contributed to high number of maternal deaths (Olanade et al., 2019).

v. Cultural Factors: Specific cultural factors are believed to contribute to maternal mortality ratio in Nigeria. For example, there are cultures that forbids a pregnant woman from eating certin foods like egg, sea foods, snails as well as taking blood through transfusion or even seek healthcare (Salami & Taiwo, 2012; Olanade et al., 2019). The resultant effect of this incidences is high iron deficiency, not taking some vaccination to protect their baby, refusal to undergo Caeserean section even when the woman is at the point of death because culturally the woman will be considered weak for not delivering naturally (Olanade et al. 2019). Culturally, women are saddled with several duties such as reproductive functions, combining these with household chores, home management and community building. Women enjoy no special attention or care during pregnancy than stress which makes them tired and experiences fatigue during pregnancy. Some cultures are so demanding on women and deny them the right to get adequate healthcare during pregnancy. There is also the issue of none involvement the male to assist or accompany their wives to ANC because they will be called "weak and woman wrapper", this is believed to be one of the reason why maternal mortality has continue to rise (Olanade et al., 2019).

Other factors included; activities of TBA/FBAs; inadequate information at antenatal visits leading to misconception, educational background, influence of parity (Amoo & Ajayi, 2019). Religion, psychosocial factors, distance to facilities, inadequate and poor health services and not adopting family planning (WHO, 2019).

SUSTAINABLE DEVELOPMENT GOALS TARGET FOR MATERNAL MORTALITY

The Sustainable Development Goals (SDGs) came into effect to replace the Millennium Development Goals (MDGs) that expired in 2015. On 25th September 2015, over 150 leaders across the globe came together and adopted a new Agenda for Sustainable Development by 2030. Seventeen (17) new SDGs known as global goals were developed and Goal 3 of primary concern to this paper because it is health related and one of its target is to reduce maternal mortality ratio to fewer

than 70 per 100,000 live births by 2030 (UNDP, 2015). Maternal mortality reduction remains a top priority under SDG three which is to is to ensure healthy lives and promote the wellbeing of all ages. While some countries have surpassed this target already, Nigeria like most countries in sub-Saharan Africa are far from achieving this target and considering that there is less than nine years to 2030 leaves much to be desired if the country will be able to reach the target set by the SDGs. It is said that no country should have greater than 140 per 100,000 live birth which is double the global target. The question is, with 814 maternal mortality ratio in Nigeria, will the country be able to achieve this target? For this to happen, it means Nigeria must increase its efforts to more than four times the current efforts because women are dying and more will continue to die unless the country become more intentional to end maternal mortality (Maternal Health Task Force, 2021). SDGs invites analysis that are efficient and effective in reducing maternal mortality globally. The three delay model must be addressed that is, delay in seeking appropriate medical help for an obstetric emergency for reason of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality; delay in reaching appropriate facility for reasons of distance, infrastructure and transports and delay is receiving adequate care when a facility is reach because they are shortage of staff, or because electricity, water or medical supplies are not available. If all this delays are not looked into, achieving the SDGs could be a mere wish (UNFPA, 2017).

POLICIES TOWARDS ACHIEVING MATERNAL MORTALITY REDUCTION IN NIGERIA

Over the years, there has been a development of several policies all geared towards reducing the maternal mortality ratio in Nigeria at all levels. One of such policy that is very prominent is the reviewed National Health Policy 2016 (FMoH, 2016). Chapter four page 28 of the National Health Policy (2016) review final copy in Nigeria States modalities on how to address reproductive, maternal, neonatal, child and adolescent health. The goal or priority of Public Health and other health challenges is a reduction in maternal morbidity and mortality (FMoH, 2016). The problem in Nigeria is that there is a lot of good policies in Nigeria, nevertheless, implementation is problem.

The policy which stem from the first put-forward in 1989 and reviewed in 2004 has great components to address mortality at all level, but at the end the incidence continues rising at the countries. The Federal Ministry of Health (FMoH) has made tremendous efforts in collaboration with partners in the last 15 years to produce and implement policies that have contributed in the improvement of maternal, newborn and child health outcome (FMoH, 2016; WHO, 2019). Another policy that has been put in place to address this issues at hand is the National Reproductive Reproductive Health Policy and Strategy (FMoH 2001) which was designed to achieve a reduction in maternal mortality through provision of quality and affordable health care in line with the 1978 Alma Ata declaration all targeting achieving universal target. There is also the national family planning and reproductive health services protocol and policy guideline and standard practice to also contribute in maternal death reduction (Uneke, Sombie et al., 2017). National Health Promotion Policy was also put in place in 2019 as well as the National Strategic Framework on health of Adolescents, health Insurance policies and Nigeria National Strategic Health Development Plan Framework 2009-2015 (FMoH, 2010). All these policies put in place were to address the determinant and causes of Maternal deaths ranging from addressing harmful practices and reproductive rights, ARH, HIV and STIs, family planning all targeting reducing maternal mortality. However, despite all the progress made in terms of MMR reduction in Nigeria, the country is progress is quite slow (Ope, 2020). It is therefore evidence that making policies is just one aspect and putting it to work is a serious matter that must be addressed is the country desire to achieve the SDG-3 target set by 2030.

ADDRESSING MATERNAL MORTALITY IN NIGERIA

The issue of maternal mortality improvement should be a key priority in Nigeria. To improve maternal health indices, hindrances hat prevent access to quality maternal health services uptake and other key factors have to be identified and addressed at both health system and societal level (WHO, 2019). Addressing maternal mortality in Nigeria requires an inter-sectional collaboration at different levels (Tulloch, 2015).

Age: One aspect that must be considered is the age of the pregnant women and women of child bearing age as those at adolescent stage and those whose pregnancy age was over 35 years have high risk of dying during pregnancy or when giving birth. The issue here is that the number and proportion of pregnancy for women aged 35 and above remain high. This is why this set of women should not take ANC and delivery with skilled health staff and facilities for proper advice, then there is bound to be continuous rise in maternal deaths (Payne, 2016). The WHO (2019) report shows that maternal deaths are highest among girls under 15 years old and complication in pregnancy and childbirth are higher among adolescent girl age 10-19 years when compared to women aged 20-24 years (WHO, 2019).

Addressing issues of family planning including contraceptive use and unmet needs of family planning will contribute in reducing maternal deaths in Nigeria the model of WHO must be adopted the South Africa approach who in section 27 of their constitution that provide that everyone has right to have access to qualify health services. In addition to age, the restriction of age of marriage and pregnancy can go a long way in reducing the incidence of maternal mortality among girls of young age and women over 35 years (Obadina, 2020).

ABORTION

Abortion remains considerably high globally and Nigeria is not an exception. In Nigeria termination of pregnancy is not legalise, abortion is only permitted when there is a threat to the live of the mother (Obadina, 2020). To tackle abortion issues countries like India and South Africa adopted certain models that worked and contributed to abortion reduction which in turn was a contributory factor to maternal death reduction. In South Africa for instance, abortion is legalise thereby recognizing the dignity of the person and right to autonomy of women and girls of reproductive age especially. Similarly, in India, the Medical Termination of Pregnancy (MTP) Act is in place, providing a legal framework for making abortion service available in India. The termination of pregnancy is allowed in India due to the model that permits for wide range of conditions upto 20 years of gestation unlike the case in Nigeria where pregnancy can only be permitted if the life of the mother is in danger (Obadina, 2020). If abortion is legalise, it will prevent especially young women from patronising quacks for abortion adding to maternal deaths.

Socioeconomic Factor

Nigeria poverty profile is on the increase as the country is adjust the poverty capital of the world. Most Nigeria live in less than a dollar each day. The standard of living of four in ten Nigerian are living in poverty in a survey conducted before 2019 and 2020 that is before the COVID-19 era were living in poverty. The implication of this is that before the advent of COVID-19, over 80 million Nigerians were living in abject poverty (Lain & Vishwanath, 2021). It is believed that by 2022 over 100.9 million will be living below the national poverty line due to the effect of COVID-19 and natural population growth (Lain & Vishwanath, 2021).

With this in mind, it is little wonder why most women will stay away from registering and going for antenatal care services in facilities/hospital with exhorbitant cost per visit rather than patronise the TBA/FBA whom they consider affordable. The

attitude of the health workers in facilities is seen by most women as unfriendly and insulting with little attention paid to them, combining this with the high cost of care, the women will go to where they can afford and still get maximum care/attention despite the negative consequences that may occur (UNFPA, 2017). Women must be economically empowered if the issue of maternal mortality is to be brought to the barest minimum.

Cultural Factor

Cultural factors should be addressed to make specific maternal mortality strategies acceptable to the community people. A case study of a culturally acceptable maternal health services is the Peru example between 1991 and 2001. In the Peru model, the implementers in consultation with the communities adapted a culturally acceptable project to provide sexual and reproductive health services for women. The result was an improvement in maternal health outcomes in the country (UNFPA, 2017). Once maternal mortality is address, it trickles down to other sector and assist in reducing severe burden on many societies.

The cross-cutting or underlying issues related to gender inequality and health systems that must be addressed in order for progress to continue and ideally accelerate (Nepal, Dangol & Kwaak, 2020). Reducing maternal mortality implies women requires good-quality reproductive healthcare, effective interventions and skilled Birth attendants and autonomy as well as resources to demand and secure access to these services in health facilities. A holistic approach is therefore needed to address this issue of maternal deaths ranging from physical and economic accessibility, to infrastructural development, information dissemination to policy formulation and implementation. In addition, healthcare facilities should be made to meet the standard as well as form partnership with the TBAs/FBAs for effective healthcare service delivery at all level (Akaba et al., 2021).

SBCC: THE SURE APPROACH TO ADDRESSING MATERNAL MORTALITY IN NIGERIA

Social and behaviour change communication (SBCC) is an interactive, researched and planned process with the aim of changing social conditions and individual behaviour. John Hopkins University (2016) opined that the SBCC strategies uses communication techniques to promote changes in knowledge, attitudes, norms, beliefs and behaviour (C-Change, 2013). SBCC is used to conduct interventions with individuals, groups and communities as it is integrated with the overall program to develop a communication strategy to promote positive behaviours that are appropriate to their settings and thereby solving the world's most pressing health challenges (C-Change, 2013). SBCC strategy provides a "road map" for changing behaviour and social norms (e,g. TBA activities). It provides a direction on how to design the SBCC campaigns and interventions, estables communication objectives, identifies intended audiences, proposes comprehensive set of interventions to encourage and support positive behaviours (Johns Hopkins University, 2022).

There are three elements of SBCC:

a. **Advocacy-** raising resources and supports from policy makers and stakeholders committed to the change goal

b**. Social Mobilisation –** Utilising different activities for wider participation and ownership, and

c. **Behaviour Change Communication (BCC)-** Changes in attitude.

SBCC combines BCC with skills building and strategies for the creation of an enabling environment for change (C-Change, 2013).

Designing an effective SBCC strategy requires a systematic process as follows:

a. **Analysing** the problem

b. Define key barriers and motivators, and

c. Designing effective messages and intervention (Johns Hopkins University, 2022).

SBCC is grounded on theories and its evidence-based program are designed based on existing data following the systematic process mentioned above (John Hopkins University 2016).

An SBCC strategy is a document that guides the design of interventions, establishing intended audiences, setting behavioural communication objectives and determining consistent messages (Dosage and intensity), materials and activities across channels.

Like the Trans Theoretical theory SBCC is the process that passes through stages of change starting from:

Unawareness → Awareness → Concerned → Knowledgeable → Motivated to change →

Practicing trail behaviour change → Sustaining behaviour change

The Following Steps are Followed in SBCC

i. State program goals

ii. Involve stakeholders

iii. Identify target population

iv. Conduct formative BCC assessment

v. Segment target population

vi. Define behaviour change objectives

vii. Define SBCC strategy and Momitoring and Evaluation plan

8. Develop communication products

9. Pretest

10. Implement and monitor

11. Evaluate and

12. Analyse feedback and revise (Family Health international, 2002, Johns Hopkins University, 2022).

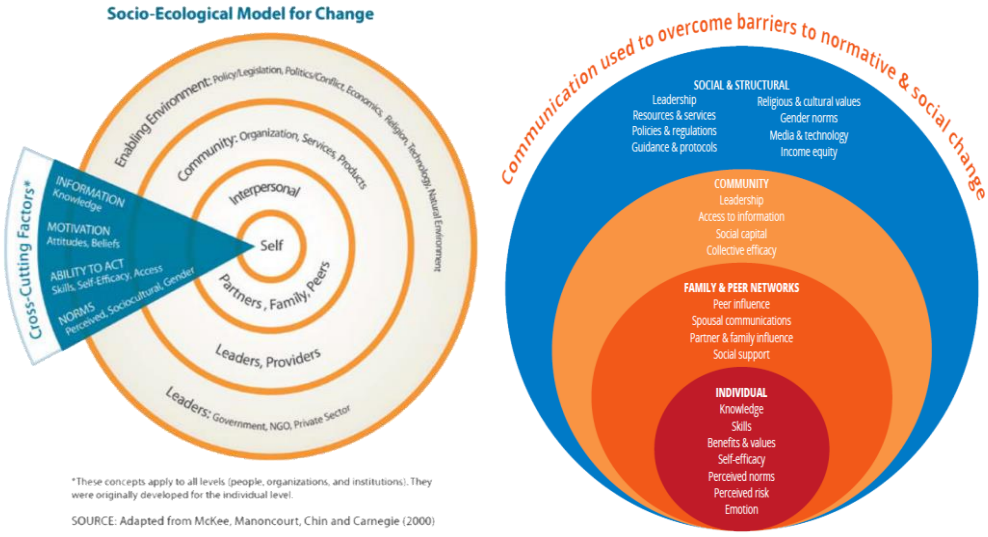

Figure1: SBCC concept and Socioecological model, adopted from C-Change 2013; (Johns Hopkins University, 2016). Available at: https://sbccimplementationkits.org/sbcc-in-emergencies/learn-about-sbcc-and-emergencies/what-is-social-and-behavior-change-communication/

EXAMPLES OF SBCCAPPLICATION TO REDUCING MATERNAL MORTALITY COMMUNITIES

SBCC has been applied in different interventions at different countries and has been found to be potent. For instance, in Malawi, when individuals demand for and creation of community commitment to improved health at the national and community level was sought. The Support Service Delivery Integration (SSDI) project was implemented using the SBCC strategy with the aim of improving Malawian families' health. This was achieved through SBCC such as interpersonal communication, small group discussions etc.

Also, in Egypt, it was utilized in the communication for healthy living project which was a cross-cutting approach for the Egyptian families with the sole aim of promoting a "Healthy Family" message – "Healthy Family, Healthy Community". Multiple SBCC approaches was employed in the public to drive home this messages and it was effective leading to the improvement in Family planning and reproductive health of women, improved maternal and child health and mitigated other Public Health threat within the country- Fig. 3 (Johns Hopkins University, 2018).

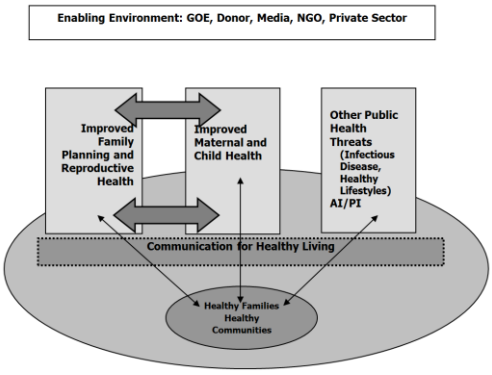

Figure 3: Egyptian Healthy families, Healthy Communities model. Source: Johns Hopkins University, 2018. Available at: https://sbccimplementationkits.org/about-designing-a-sbcc-strategy-i-kit/example-creating-a-strategic-framework/

In Guatemala the story was not different when the employed the SBCC campaigns in the "Seeds of Change" project that adapted radio drama and serial documentaries as the SBCC approach that was used at the end the testimonies numerous. One of the participants posits Ï had never dreamt that I'd be asked to share my story… I am so thrilled and thankful that my life can inspire others to change". The Chief of party of Health Communication Capacity Collaborative (HC3) in Guetamala added that "Hearing the voices of change from the grassroots level was deeply moving to the audience and symbolizes the change that Guetemalans are embracing in improving the health of their families" (Johns Hopkins University, 2022).

In Nigeria the story has not been different as Chizobo Onyechi one of the Champion of Family Planning shared her success story of using SBCC to bridge the huge knowledge gap among young women and women of reproductive age. According to her "… They were stranded in many ways, they didn't want to become pregnant, but they didn't know how to prevent pregnancy. Often, they were being misled, I feel that if people are well informed using the right approach, the half of our problems are solved" (Johns Hopkins University, 2022).

In Cross River State, I have worked with organisation DreamBoat, that has been supported on different occasions with grant to implement SBCC centred projects. Between 2010-2013, the organisation used SBCC to prevent HIV spread among Tertiary youths in University of Calabar and Cross River State University of Technology (now University of Cross River State) and four (4) secondary Schools in Calabar Municipality. It was quite successful. They organisation used Small Group discussions, drama, quarterly PTA or Stakeholders meeting, rallies, Campus talk shows and so on to ensure the Minimum Prevention Package Intervention was achieved and at the end more persons were reach with HIV Testing and Counselling (HTc) even at the secondary School level (DreamBoat Theatre for development Foundation, 2014). It was also used by the Improving Access to ANC, PMTCT and Comprehensive Treatments Services (IMPACTS) project which DreamBoat was part of the Consortium and one the achievement was increase in demand among community women. The SBCC approach is tested and trusted, but it has it challenges Positive Care and Development Foundation 2019).

CHALLENGES OF SBCC IMPLEMENTATION IN NIGERIA

1. **Poor Funding of the Intervention:** Funders are after target and thus do not follow through the ideal process of delivering SBCC intervention

2. **COVID-19 Pandemic Restrictions and Observation of Protocols** signifies that with the social distancing rule in place and the use of face masks, most community women cannot gather at the same time and this disrupt the intervention which is aimed at taking outreach with the needed services to the community because most of them do not go to the health facilities for ANC and other services.

3. **Endsars Protest:** The EndSars protest resulted in carting away of HIV Test kits and other commodities which has prevented most pregnant women who are at the verge of delivering their babies from knowing the HIV status. This is dangerous as it may result in more children being delivered with HIV.

4. Poor information about the conscious use of the SBCC strategies that could result in the needed change and the activities of TBAs

CONCLUSIONS

The rate of maternal mortality has continued to rise and slightly fall (WHO, 2019) and this could be as a result of not using or sustaining the strategies that works due to insufficient funding and donor fatigue. But if SBCC approach is made known

to many setting and the know that the use of entertainment education for instance can be a viable tool for the repaid reduction of maternal mortality when combine with the availability of require services. There is no reason why a mother should die while giving birth to a child or a child being infected because the mother is HIV positive and if it results to AIDS could mean the child also may loss the mother. With the use of SBCC, this can be achieved at minimal cost provided the policy makers and community stakeholders are will to be involved in the process and create enabling environment for individual to adopt the change in behaviour concept being market through SBCC as a social marketing strategies. Until the right approach is adopted, it may be difficult to cause the desired change which is a reduction in maternal mortality in Nigeria.

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