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PROLIFERATION AND COMMERCIALIZATION OF BIRTH DELIVERY AS CATALYST TO HIDDEN MATERNAL MORTALITY IN ILORIN EMIRATE, NIGERIA, 1999 TO 2020

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Abstract

Since the 1960s, the burden recorded from the persisting cases of maternal and neonatal health problems in Ilorin Emirate, Nigeria, cannot be overemphasized. These problems were borne out of the disparity in access to standard orthodox healthcare, most especially at the grass root level. The military regimes responded by launching and intensifying efforts and strategies towards combating the scourge and safeguarding the good health of all. In 1986, they ensured the execution of the 1978 Alma Ata declaration by establishing and funding Basic Health Centres in all political wards of Nigeria. As of the year 2000, however, the subsequent democratically elected governments castrated and frustrated the effective implementation of the "health for all", thereby triggering the proliferation and commercialization of maternal health care in the Ilorin Emirate. The study adopts historical method of data analysis using primary and secondary sources to juxtapose the intensifying magnitude of hidden maternal mortality as the repercussion of excessive proliferation and commercialization of maternal health care in the Ilorin Emirate. Using purposive sampling, oral interviews were conducted with traditional birth attendants, Community Health Extension Workers (CHEW), church birth attendants, medicine store birth attendants, retired nurses, medical doctors, pregnant mothers, and other hospital supporting staff. Information sourced proclaimed the extent through which excessive commercialization of birth delivery, accompanied by other vices such as the quest for an alternative means of livelihood, religious fanaticism, impunity and misplacement of priorities, have compounded the already worsened unreported and hidden maternal and infant mortality context in twenty-first century Ilorin health history.

Keywords: Maternal, Mortality, Morbidity, Hidden Deaths, Ilorin Emirate

Introduction

Maternal health signifies and encompasses all aspects of women's healthcare during pregnancy, childbirth and postnatal period. It starts with antenatal care comprising medical examinations of blood, urine, and blood pressure, pregnancy health talk, counselling education and general medication during pregnancy, such as antimalarial prophylaxis, antitetanus toxoid, and others. Other significant aspects connote the care she receives during child's birth and delivery, which ranges from medication, positioning during delivery and standard care deserved by pregnant women, such

BIRTH MATERNAL 2020

As hygiene and prompt responses to her health demands. Maternal mortality signifies the death of a pregnant woman within a few weeks and up to one year of birth delivery, resulting from pregnancy-related complications and conditions. The World Health Organisation (WHO) defines maternal mortality as the death of a pregnant woman due to complications related to pregnancy, underlying conditions worsened by the pregnancy, or management of these conditions. This can occur either while she is pregnant or within six weeks of the resolution of pregnancy.¹ These conditions are either directly or indirectly pregnancy related in nature. Direct causes of maternal deaths are as a result of pregnancy related complications or injuries and infections. For example, these could range from severe bleeding to obstructed labour, for which there are highly effective interventions.² obstetric haemorrhage, pregnancy-induced hypertension, pregnancy-related anemia, and post-abortion deaths, among others. Indirect conditions are those subsisting ailments such as fibroid, malaria, pulmonary tuberculosis, HIV/AIDS, heart problems, cancer, etc. These ailments are worsened by the interference of pregnancy.

Several reasons or factors have been popularly advanced for the continuous and increasing occurrence of maternal mortality and morbidity in several parts of Nigeria and the Ilorin Emirate since the second half of the 20th century. Scholars and health organisations such as the World Health Organisation (WHO), United Nations International Children's Emergency Fund (UNICEF), World Bank and the Federal Ministry of Health (FMOH) have advanced factors such as inadequate coverage of health facilities, low level of women education, lack of access to information on quality health care, patronage of traditional birth attendants (TBSSs), cultures such as early marriage, teenage pregnancy, lack of women autonomy and preference for home delivery, lack of financial capability, distant health facilities and numerous others. Several literature written and published in the late 20th and 21st centuries have highlighted the efforts and measures in terms of aid, materials and facilities initiated by international and national agencies toward ameliorating and rectifying the poor maternal health indices.

With the highlighted causes and solutions of maternal mortality and morbidity, and the provision of these huge investments in maternal health care in Nigeria and Kwara State, and Ilorin Emirate in particular, one would have expected optimum utilization, positive impact and a negligible maternal mortality ratio. Unfortunately, the reverse was the case. Developing countries such as Nigeria continued to wallow in maternal mortality and morbidity to the extent Nigeria loses 145 women of childbearing age daily, making her the second largest contributor to the maternal mortality rate in the world behind India.³ Furthermore, pregnancy and childbirth and their consequences are still the leading causes of death, diseases and disability among women of reproductive age in Nigeria and other developing countries more than any other single health problem.⁴ Worldwide, an estimated half a million women die each year from complications from pregnancies and childbirth: of this, 55000 maternal deaths occur in Nigeria alone.⁵

The research gap in maternal mortality and morbidity created by the proliferation of several categories of birth attendants in the Ilorin Emirate and several other parts of Nigeria has been left unnoticed and undocumented. The contemporary physical, geographical, demographic expansion and upsurge in population encountered by Ilorin Emirate between 2000 and 2020 contributed inordinately not only to the growing number of casual and commercial birth attendants but also hidden and unreported mortality and morbidity in Ilorin Emirate. The researcher found out and proved that, although the above-listed causal factors are still in vogue, commercialisation and



proliferation of birth delivery in the Ilorin Emirate and other parts of Nigeria became the new circumstances behind a number of factors uncovered in this study. The thrust of this study is, therefore, a historical appraisal of contemporary contributing factors to the rising maternal mortality and morbidity contexts in Ilorin Emirate, Kwara State of Nigeria, with a view to bridging the research gap in obstetric health studies.

Failure of Primary Health Care System and Proliferation of Casual Birth Delivery

In the past and even to date, traditional midwives and professional birth attendants (TBAs) took an active role in ensuring and sustaining the healthcare of pregnant women before, during and after delivery. Availability, grassroots-based, affordability, customs and traditions helped to nourish and flourish traditional maternal healthcare in the Ilorin emirate. The African principle of communalism became the guiding principle and backbone of maternal healthcare in the Ilorin emirate. Apart from the fact that professional traditional birth attendants were at the service of the pregnant mothers, experienced mothers and married women also assisted during the antenatal and perinatal period. In the colonial period, the traditional birth attendants competed conveniently with the missionaries and 'Native Authority's maternal health services to sustain the maternal and fetal healthy living of the people of the Ilorin emirate. Colonial indirect rule system bequeathed a substantial portion of orthodox primary health care in the districts and interior parts to Christian missionary medical work. At the time of the attainment of independence in 1960, the subsequent indigenous ruling elites focused their attention on secondary and tertiary health institutions. The previously awarded grant-in-aid and other financial and moral support for the mission hospitals and other voluntary health facilities came to a halt. Several efforts, calls, Save Our Soul (SOS) requests from the affected communities in Ilorin province fell into the deaf ears of the concerned authorities.⁶ Many of these missions in Ilorin Province responded by terminating their health care service, and rather concentrated fully on evangelism.⁷ It was a few missions, such as Sudan Interior Mission (SIM), the Methodist church and a few others that proceeded with medical activities and run their affairs on a commercial basis. By 1960 therefore, significant emphasis on healthcare development at the grass root level became a mirage.

Realizing that the lack of proper health care at the grass root level was wreaking a lot of havoc in Nigeria and other developing countries of the world, the Alma-Ata Declaration of September 1978 was urgently recommended by the World Health Organization (WHO) as the key to achieving the goal of "Health for All". Professor Olikoye Ransome-Kuti, appointed Minister of Health in 1985, was tagged the father and pioneer of primary health care in Nigeria. On his inception of office, he realized the desolate state of primary healthcare in Nigeria needed urgent attention. He plunged into action by his instantaneous implementation of the recommendations of the Alma-Ata Declaration of 1978. He adopted Primary Health Care (PHC) in 52 Local Governments to test-run the Alma-Ata Declaration and the Nigeria's first Comprehensive National Health Policy was launched in 1988. From 1986 to 1990, Professor Olikoye Ransome-Kuti expanded primary health care to all local governments, achieved universal child immunization of over 80%, and devolved responsibility for PHC to local government areas.⁸ In order to further extend the tentacles of primary health care to the grassroots, he masterminded the establishment of the National Primary Healthcare Development Agency (NPHCDA) in 1992. The agency ensured the utilization of the electoral ward as the basic operational unit for primary health care delivery.⁹ Execution of the programs of the agency takes

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into consideration Nigeria's common health burdens, such as maternal and infant morbidity and mortality and infectious diseases.

These primary and grassroots primary health care interventions were credited to have been poignant, impressive and sustainable under the military dictatorship, and its sustainability was challenged and threatened by the advent of democracy in 1999.¹⁰ Babangida and the subsequent military governments adequately funded these outlined schemes. At the State level, the National Primary Healthcare Development Agency (NPHCDA) monitored the primary healthcare facilities and programs in every political wards. Moreover, the autonomy and independence accorded to the Local government finances inspired the optimal performance and success of the project. Henceforth, 13% of the local government's monthly allocation was devoted to the health sector, majorly comprising of funding of the basic health centers at the ward level. The military regimes ensured consistent supply of basic health facilities needed in the maternity ward, and these were meant for free of charge or at a lower cost. Ante-natal, post-natal and children's immunization were all administered at a lower and affordable rates in these health centers during the military regime. In fact, pregnant mothers ready for labour were required to provide only deodorants used in cleaning the toilets and labour room and nothing more.¹¹ These ward basic health centers recorded the highest of their patronages during this period. Although Medical Doctors were not employed in these hospitals, the nurses, Community Health Extension Workers (CHEW) and Voluntary Health Workers were steadily deployed and redeployed, devoted and dedicated to maternal and infant health care and other services rendered.

However, distortion and unduly interference in the activities and finances of the local governments by democratically elected civilian dispensations since 1999/2000 had a terrible and unfavorable effect on primary health care in Nigeria. The democratically elected Nigeria's States Governors intruded inordinately into the local government affairs and finances. The local government's monthly subvention and allocation and internally generated revenues were henceforth hijacked, decimated, and fragmented by the Nigerian State Governors. These malevolence were justified under the pretense of the local government chairmen's purported overzealousness and corrupt practices. Thence, the local governments' monthly allocations from the Federation Account Allocation Committee (FAAC) were forcefully conscripted and coerced into "joint allocation" under the guise of proper resource management by the Governors. Unfortunately, however, the reverse was the case. The Governors, through the States' Ministry of Finance, became umpires and re-allocating stipends, which obstructed and distorted the smooth running of the local governments' affairs. Funding essential and basic responsibilities such as primary health care and infrastructures became arduous, and the local government was rendered a redundant tier of government in Nigeria. Usurpation of the financial power of the local governments plummeted her into further ruins. For instance, in Kwara State, the State Governor in 2007 forcefully conscripted the local government into the purported "Joint Project". As if the burden of the joint allocation on the local governments was not enough, the "Joint Project" authorized the State Government's withdrawal of the desired amount from each council into a common pool meant for the purported jointly financed projects.

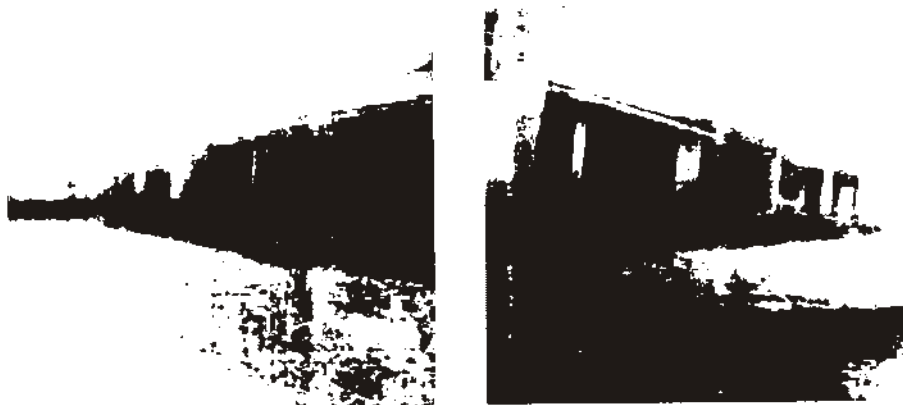
The overburdened local government finances impacted deleteriously on the funding of basic health centers in Kwara State. The health centers that had previously attended to the care of pregnant women and infants were left to their faith and the shadows of themselves. Many of them were left without medical supplies for years, while others were abandoned to wallow in ruins and dilapidation.

Figure 1 and 2: Dilapidated and Abandoned Basic Health Centre, Moya Ward, Moro Local Government, Kwara State, Nigeria.



Source: Picture taken by the Researcher on 11/03/2021

Figure 3 and 4: Dilapidated and Abandoned Mogaji Basic Health Centre, Akanbi Ward 2, Ilorin South Local Government Area, Kwara State, Nigeria.



Source: Pictures taken by the Researcher on 22/12/2021

Equipment, staff uniforms, MUAC (a tape for detecting infant malnutrition), drugs such as veron, yonic, volic acid, paracetamol, chloroquine, Flagyl, and anti-malaria like Quatem, SP, and Vitamin A that were previously and consistently supplied to the basic health centres at subsidized rates for antenatal and postnatal treatments in the 1980s, became a nightmare in the years 2000 and above.¹² In fact, the bulk of health care intervention in terms of drugs, vaccines and equipment in the basic health centres were sponsored by international organizations such as World Health Organization (WHO) that offered support on polio immunization, UNICEF providing tetanus toxoid and

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3.1.1. Moro Local

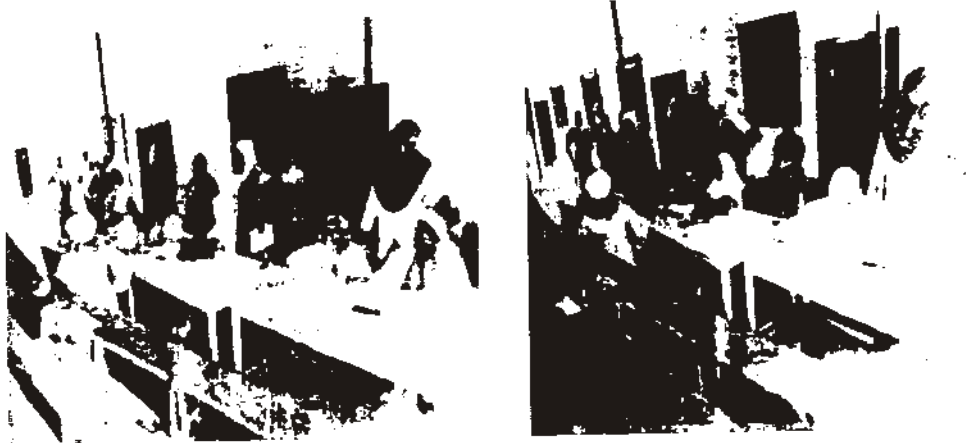
Diphtheria containing vaccines (MNT-TD) and international non-governmental organization such as Marie Stopes delivering sexual and reproductive health services among few others.¹³ More so, Health Educators that had functioned prominently in the 1980s and 1990s were rendered redundant. These Health Educators had gone around the streets and villages to campaign, educate and enlighten pregnant women on the importance of hospital care (such as the importance of vaccines against tetanus and polio), and dangers inherent in home delivery, traditional birth attendant services, and other casual and commercial birth attendants.¹⁴ From the year 2000 to the terminal point of this research, non-supply and non-availability of essential drugs and equipment impelled the basic health centres' workers to contribute money among them to purchase these drugs and sell them to pregnant women during the antenatal and post-natal period.¹⁵

3.1.2. Ilorin

In a similar manner, dwindling local government funds stagnated health staff reinforcement in the basic health centres. Precisely in Kwara State, the last time medical and health workers were employed massively in the Local Government Basic Health Centres was between 2013 and 2014. Contracting out the local government staff salary payment to a private consultant firm in 2014 automatically placed an embargo on employment in the councils.¹⁶ From then henceforth, the staff of the whole 16 local government received their salary from the central payment point, and the salary unit of the treasury department of all the local governments became worthless. As the old staff retired, the government justified the paucity of funds at the local government level as the reason for the non-recruitment and non-redeployment of new staff to the basic health centres. For instance, the health staff in the payroll of Ilorin West Local Government was 350 in 2014.¹⁷

As the nurses, community health workers and other categories retired without replacement, the number descended to 287 in 2019 and 253 in 2020.¹⁸ It is important to note that in the 1980s and 1990s, each basic health centre had at least 15 nurses and community health extension workers, 10 to 12 attendants and three-night watchmen. In 2000 and 2020, the number declined to 5 to 6 nurses and community health extension workers, 2 to 3 attendants, and none had watchmen. In fact, the health centres always appeared unkept and untidy due to few attendants on and off duties.¹⁹ Few that had watchmen paid such casual staff from the hospital's pulse.²⁰ The previously employed voluntary health workers chosen from the community level, and had helped during emergencies, were relieved of their duties due to paucity of funds. The researcher found out that most of the caregivers in the basic health centres within the time frame of this research were nursing and community health practical students observing their three months of clinical posting or practical training. After the practical training of these students, the basic health centres were left with a few permanent staff that were incapable of dealing with the maternal health care needs of their wards and communities.

Figure 5 and 6: Students observing 3 months clinical posting at Basic Health Centre, Ipata Oloje



Source: Pictures taken by the Researcher on 2/1/2022

The resultant effect of this situation was that many pregnant women and sick infants at the grassroots level were forced to seek medical attention from several categories of commercialized and casualized birth delivery centers such as auxiliary nursing homes, casual and Para-medical health care providers, traditional midwives, and private hospital operated by non-professional obstetricians and gynecologists. These aforementioned categories of health care providers turned 'Doctors' overnight. They engaged in maternal health practices that were beyond their capabilities, thereby contributing to several cases of hidden and unreported morbidity and mortality. Medicine store owners did not only train auxiliary nurses massively, they also engaged in casual birth delivery in their tattered residential and rented apartments.²¹

As their business became more lucrative and profitable, scores of these medicine store operators, faith-based homes and traditional midwives advanced to ownership of private hospitals, where maternal and infant health care were administered. No wonder the majority of the private hospitals in Ilorin emirate were owned and run by these birth attendants, in cooperation and patronship of the orthodox health practitioners. They manipulated their ways to secure genuine registration and approval of their hospitals. These hospitals were registered using the certificates of certified medical doctors. A number of community health extension workers (CHEW) became known as birth attendants in their localities. In the interior parts of Ilorin Emirate, the bad condition of the primary health center, where these nurses and communities health extension workers operated, prompted some of them to establish their own private clinics where patients were diverted.

Figure 7: A Market in Ilorin



Source: Pictures taken by the Researcher on 2/1/2022

Urbanization

One of the important factors in the expansion and development of Ilorin town and its surroundings was the influx of people from other parts of the state and neighboring states. This was due to the fact that Ilorin was one of the most important towns in the state and it was the only town in the state that had a large population. This was due to the fact that Ilorin was one of the most important towns in the state and it was the only town in the state that had a large population. This was due to the fact that Ilorin was one of the most important towns in the state and it was the only town in the state that had a large population.

Drastic physical changes were made into a hub of economic activity. Despite the fact that the town was small, it was especially in the area of health care.

Centre, Ipatu Oloje

Figure 7: A Maternity Home Operated by a CHEW and an Employee of Basic Health Center at Ifon



Source: Picture taken by the Researcher on 23/12/2021

Urbanization, physical and Demographic Change and Proliferation of Birth Attendants

It is important to note that 2000 and 2020 marked a rapid growth in built-up land, urban spatial expansion and excessive reduction in vegetation areas. As the population increases, the construction of dwellings also increases, thus, engendering the conversion of crop land and forest land to settlement.²² For instance, the built-up land from 1986 to 2000 was 7091 hectares, which rose drastically to 9158 hectares and 18086 hectares in the years 2000 and 2006, respectively.²³ The 1980s and 1990s witnessed the opening up of several interior areas of the Ilorin city beyond the aboriginal boundaries. Thus, areas covering places such as Fate, Agbabiaka, Adewole, Odota, Kilanko, Kulende, and Gaa-Akanbi, among numerous others, were built up and drastically populated. Developments at the beginning of the new millennium in the year 2000 attested to the extensive opening and building up of new areas to the extent that, several parts of metropolitan and rural areas of Ilorin Emirate were linked up by residential building, and boundaries delineation became a herculean task. Areas and villages such as Eiyenkorin, Ogele, Ballah, Ogbondoroko, Sapati, Ganmo, Abayowo, Osin, Aliara and several others that fall under Asa and Ilorin West Local Governments were thereby linked up with the metropolitan Ilorin city. More so, areas and villages such as Gaa Osibi, Alagbado, Sobi, Shao, Oko-Olowo and others that fall under Ilorin South and Moro Local Government Areas transformed from agrarian to residential pattern and got linked up with the economy of the Ilorin city.

Drastic physical and demographic changes in Ilorin Emirate between 2000 and 2020 transposed it into a hub of divergent activities ranging from economics to political, traditional, and medical. Despite the purported strict regulation of these activities by the concerned constituted authorities, especially in the medical and health sector; deviant, illegal and quack practitioners manipulated and

compromised due process. Hence, Ilorin Emirate became a fulcrum of casual and highly commercialized health centres such as those owned by medical doctors, patient's medicine stores and auxiliary nurses, faith-based maternity homes, traditional birth attendants, and health centres owned by unqualified para-medical practitioners such as diploma holders in pharmacy and health educators. Their service was not only easily accessible but also affordable to the people in their local communities. One of the devastating effects of commercialization and proliferation of health centre most especially maternal healthcare was unrecorded and hidden mortalities and morbidities. These mortalities became unreported and hidden based on the agreement and mutual consent of the deceased families and the practitioners involved. The fear of threats from diabolical and spiritual attacks also prompted the deceased families to remain mute on the death of their relatives. Indigenous, Islamic and Christian religious beliefs that only Almighty God taketh and giveth lives also restricted the Ilorin Emirate people from reporting maternal mortalities that occurred in these centres to appropriate authorities.

Misconceptions Surrounding Caesarean Section (C/S)

Popular myth, customs, spiritual affinity and cultural belief associated with infertility and caesarean section (C/S) was one of the major factors of morbidity and mortality among traditional midwives, faith-based maternity homes and other commercial and casual birth attendants. Caesarean section was a major obstetric intervention introduced in the late nineteen century to save the lives of women and their newborns from life-threatening pregnancy and childbirth related complications.²⁴ Most Ilorin Emirate people believed that these traditional midwives and faith-based homes have spiritual prowess and herbal components to cure infertility and prevent surgery or caesarian section.²⁵ The people perceived the caesarian section as a painful and risky delivery option, which is very expensive and beyond the financial capabilities of the common people.²⁶ In fact, the prayer that *won a ni fi ohe ghe' bi ni imu e* (may you not be delivered via surgery/ C/S) indicates that delivery through C/S is perceived as an unfortunate predicament among the people.²⁷ Superstitious notions that these traditionalists and casual birth attendants have the spiritual powers to control and manipulate the size of the placenta to avoid C/S and to influence the turning of the baby's breech position to head presentation further boosted not only their popularity,²⁸ but also unreported morbidities and mortalities. The researcher has, however debunked the peoples' erroneous belief and ignorance of caesarean section as a mere illusion through the tertiary health facility maternal health care data. These data reiterated that, despite the rate of the CS accomplished in the University of Teaching Hospital between 2000 and 2020, fewer and insignificant mortality rates were recorded. This further laid credence to the notion that CS in standard health facilities was one of the delivery options meant to save lives from life-threatening pregnancy and childbirth related complications.



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Table 1: The rate of Caesarean Section (C/S) in University of Ilorin Teaching Hospital (UIITH), 2000 to 2020

Years	No. of C/S	Year	No. of C/S
2000	416	2011	744
2001	550	2012	866
2002	810	2013	746
2003	725	2014	547
2004	803	2015	707
2005	702	2016	669
2006	807	2017	705
2007	653	2018	-
2008	780	2019	-
2009	779	2020	-
2010	837		

Source: University of Ilorin Teaching Hospital Data Bank

Table 2: Maternal Mortality Rate in University of Ilorin Teaching Hospital (UIITH), 2000 to 2020

Years	No. of Mortality	Year	No. of Mortality
2000	1	2011	16
2001	0	2012	35
2002	3	2013	1
2003	3	2014	2
2004	1	2015	15
2005	1	2016	2
2006	1	2017	5
2007	0	2018	3
2008	1	2019	9
2009	0	2020	-
2010	6		

Source: University of Ilorin Teaching Hospital Data Bank

Casual Birth Attendant and Over-Stepped Boundaries

The researcher discovered that the unhygienic herbal concoction and polluted prayer substances administered to pregnant mothers during antenatal care resulted in adverse health reactions. In most cases, these had resulted in intra uterine fetal death (IUFD), and intra uterine growth restriction (IUGR), which made babies weigh below 3.5kg.²⁹ Furthermore, the use of unsterilized sharp objects for scarification marks meant to ensure and sustain spiritual protection and easy delivery was also found to have infected the mothers and fetus with infections such as syphilis, tetanus, HIV, Hepatitis B and several others.³⁰ These morbidities and mortalities were also perpetrated by the unkept and dirty delivery rooms, making it a high risk for the mother and baby.

It is important to acknowledge that few among these casual birth attendants adopted diversification and diffusion of ideas and techniques of orthodox health care, which gave rise to the monitoring their patients' blood pressure on a constant basis and relying on ultrasound scans to monitor the condition of the placenta and the position of the baby in the womb. Similarly, some adopted orthodox hospital delivery techniques and labour room settings.

Figure 8: Labour Room of Traditional Birth Home at Elere Compound, Pakata Road, Ilorin



Source: Picture taken by Researcher on 8/10/2021

Scores of others were restricted by naivety, ignorance, over-reliance on age-long tradition, spiritual prowess, prayers, diabolism and taboos. It thereby became difficult for them to empirically investigate and monitor the level of progress and setback in maternal and fetal health. Consequently, medical conditions such as preeclampsia/Eclampsia inflicted by high blood pressure has killed many pregnant women undergoing delivery in the custody of these commercial birth attendants.³¹ Similarly, casual birth delivery without the use of a scan to investigate the location of the placenta and condition of the uterus had resulted in antepartum haemorrhage and postpartum haemorrhage, which is excessive bleeding through the vagina due to abnormal location of the placenta, ruptured uterus and cervical laceration. Their ignorance and inability to monitor the progress associated with childbirth has led to obstructed labour and death of the fetus and mother. A number of patients that turned out to be unconscious due to these complications were emergently referred and treated at the obstetrics and gynecology wards and intensive care units ICU of the Kwara State General Hospital and University of Ilorin Teaching Hospital (UIHH).³² The immensity of these maternal health hurdles got deeply entrenched to the extent that referrals to the UIHH, which was the main reference point, increased geometrically since the year 2000 upward.

Table 3: Number of Patients Delivered at Ilorin Teaching Hospital (1995-1999)

Year	Number of Patients
1995	120
1996	130
1997	140
1998	150
1999	160

Source: UIHH Records

Moreover, the lack of health education and sensitization of the community on the dangers of traditional birth attendants has also contributed to the high incidence of maternal and fetal deaths. The community is still largely ignorant of the dangers of traditional birth attendants, especially those who are untrained and unqualified. This has led to a high number of maternal and fetal deaths, which is a major public health problem in the region.

Conspiratorial practices of traditional birth attendants have also contributed to the high incidence of maternal and fetal deaths. These practices include the use of harmful substances, such as herbs and oils, which can cause complications during delivery. Additionally, the lack of proper hygiene and sterile environment during delivery has also contributed to the high incidence of infections and complications.

Table 3: Number of Referrals from outside to the Obstetrics and Gynecology ward of the University of Ilorin Teaching Hospital (UTH), 1995 to 2020

Year	No. of Referrals	Years	No. of Referrals	Years	No. of Referrals
1995	4194	2000	4444	2011	5508
1996	4504	2001	6215	2012	7195
1997	2286	2002	6839	2013	5798
1998	2181	2003	7073	2014	7175
1999	2595	2004	6139	2015	6220
		2005	6207	2016	5221
		2006	6445	2017	4543
		2007	6596	2018	4636
		2008	7258	2019	6820
		2009	5345	2020	6705
		2010	4640		

Source: University of Ilorin Teaching Hospital (UTH) Data Bank and Researcher's Estimates

Moreover, the awkward practice of some casual birth attendants has turned Ilorin Emirate into a haven of hidden and unreported neonatal morbidities and mortalities. Obviously, their improper management of poor baby cries has led hundreds of babies to perinatal asphyxia (brain death).³³ It was also common among the midwives, most especially the faith based homes, to introduce diabolical ashes and spiritual olive oil to the belly button umbilicus of babies. This method had killed and infected countless babies with neonatal tetanus, resulting in genetic seizure otherwise known as *Giri*, among Ilorin Emirate people.³⁴ Anemia constitutes a major infection burden on the babies delivered at these commercialized maternal health centres in Ilorin Emirate. Pregnant women attending antenatal and perinatal care in these casual and commercialized birth delivery clinics lacked maternal health education and information concerning repeated pregnancy and morbidities such as anemia. In the basic health centres, general hospitals and teaching hospitals, professional health educators and counselors advise pregnant women on the dangers of anemia and are thereby sensitized to replenish the nutrients and optimize the pack cell volume (PVC), leaving the interval of at least one year before the next pregnancy. Anemia has wreaked havoc in the Ilorin Emirate and several parts of Nigeria with consequential mortalities and morbidities such as mental disorders in babies, the babies not developing well, diabetes in adulthood, mental retardation and cardiac problem in later life.³⁵

Conspiracy between these aforementioned commercial birth attendants and qualified orthodox practitioners further strengthened the magnitudes of the hidden maternal fatalities. Many of them had at least one or two part-time medical doctors or nurses in their employ, who were called upon during emergencies, to help when encountering difficult delivery or surgery, diagnose blood samples, secure authorized signature for specified drugs, and serve as referral points. These qualified medical practitioners, many of who worked in private and, in rare cases, public health facilities, were aware of these hidden mortalities and morbidities. Their share of the proceeds of these anomalies i.e., monetary benefits and gains allured their cooperation and collaboration and restrained them from disclosing the escapades of the commercial birth attendants.



Furthermore, the private hospitals owned by certified medical doctors who are not qualified obstetricians and gynecologists are also wrecking noticeable, hidden and unreported havoc in the maternal health realm of the Ilorin Emirate. Many of the private clinics, in most cases, served as epicentres of quackery.³⁶ Engaging in complicated maternal surgical procedures meant for consultant obstetricians and gynecologists automatically qualifies non-specialist operators as quacks in that aspect.³⁷ Apparently, a series of unethical medical practices perpetrated solely for commercial purposes, which led to cases of unreported mortalities and morbidities, are the norm among private clinics in Ilorin Emirate and Nigeria in general. In many of these hospitals, complicated surgical procedures that ought to have been operated by professional obstetricians and gynecologists were handled by quacks (Quacks here are medical doctors that do not specialize in O&G).³⁸ Cases of insertion of pads to the private part of pregnant women on antenatal visits, forgetting sanitary pads, scissors and other surgical instruments in the stomach of the victims during CS, and poor handling of complicated maternal cases among others have worsened maternal mortality and morbidity in Ilorin Emirate and several parts of the country.³⁹ These non-professionals handling maternal health cases have killed quite a number of unspecified and non-reported numbers of people. These horrific scenarios got deeply entrenched to the extent that the people living in the neighborhood of many of these hospitals have tagged them "the killer's den."⁴⁰

Conclusion

Efforts and strategies have been intensified by governments, international health donors and agencies towards minimizing and eradicating the scourge of maternal mortality and morbidity in Nigeria and several other parts of the world. Globally, the Alma-Ata Declaration of 1978 recommended standardized maternal healthcare techniques, ideas, and methods of trivializing the spate of maternal and infant mortality. Prioritization of access to quality and affordable primary health care at the grassroots dominated the context of the impactful Alma-Ata Declaration. The Nigerian military governments of 1986 and above embraced these gestures by implementing strategies towards extending the tentacles of maternal healthcare to the grassroots. Subsequent civilian administrations' inconsistencies since 2000 compromised the previously and perfectly executed primary health policies. Discrepancies ranging from inadequate funding, staffing, and supervision, wittingly shifted the responsibilities of 'health for all' to commercial and casual health mongers, with its consequent hidden maternal mortalities and morbidities.

The subsequent physical and demographic expansion further triggered and complicated the proliferation and commercialization of maternal health care in the Ilorin Emirate. Their activities got deeply entrenched to the extent that mortalities and morbidities were hidden, unreported and not accounted for. The magnitude of these hidden and silent deaths and morbidities has turned many into orphans, widowers, and series of unwarranted disabilities.

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4. WHO 2005. World Health Report 2005: Making Every Mother and Child Count. http://www.who.int/whr/2005/whr2005_en.pdf. Retrieved on 06/9/2021. WHO 2006. Neonatal and Perinatal Mortality: Country Regional and Global Estimates. Retrived from <Http://apps.who.int/iris/bitstream/handle/>. WHO 2010. Trends in Maternal Mortality: 1900 to 2018-Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank. <http://whqlibdoc.who.int/publications>. Retrieved on 22/5/2022. WHO. 2012. State of the World's Children 2012. <http://www.unicef.org/sowc2012/pdfs/sowc-2012>. Retrieved on 22/5/2022. Anderson, I. et al. 2011. The other Crisis: The Economics and Financing of Maternal, Newborn and Child Health in Asia. *Health Policy and Planning*. Vol. 26. No. 4. 288-297.
5. HERFON. 2006. Maternal Health in Nigeria. *Nigerian Health Review*. Abuja. Kenbrin Press Limited. 1003-20.
6. NAK. SC.P.9. GENERAL. Headquarter, Ilorin Province. Appeal for Help. January 6, 1958. Sudan Interior Mission (SIM) stationed in Iwo Isin and served the whole of Ile-Ire, Owu-Isin, Iwo, Oro and several other towns and villages were among those that benefitted immensely from the services offered by the dispensary. Services were abandoned due to the stoppage of the grant-in-aid by the emerging indigenous leaders. The dispensary was said to have helped with at least 200 birth delivery on an annual basis. Mr. Silas Aboyeji was among the first set of indigenous Nurses in Ilorin province, and his meritorious service in safeguarding the health of his people through this dispensary cannot be overemphasized. Despite several pleas and save our soul letters written by the paramount ruler of Iwo and his chiefs, the dispensary was left to wallow in ruinage.
7. NAK. SC.P.9. GENERAL. Headquarter, Ilorin Province. Appeal for Help. January 6, 1958.
8. Bolaji, S. A. and Samira, M. 2017. Primary Health Care in Nigeria: 24 Years After Olikoye Ransome-Kuti's Leadership. *Public Health*. Doi:10.33.89/fpubh. 2017.00048. Accessed on 15/03/2022. Professor Olikoye Ransome-Kuti's laudable achievement in the proliferation of government and standardized Basic Health Care at the grassroots level towards achieving the "Health for All" insignia of the Alma Ata declaration of 1978 tagged him the "Father of Primary Healthcare in Nigeria".
9. Aigbiremolen. A.O. et al. 2014. Primary Health Care in Nigeria: from Conceptualization to Implementation. *Journal of Medical and Applied Bioscience*. Vol. 6. No. 2. 35-43.



10. Aigbiremolen, A.O. et al. 2014. Primary Health Care in Nigeria: from Conceptualization to Implementation.
11. Oral interview with Alhaja Fatima Musa, retired Chief Community Health Extension Officer. No. 4. Ipata Oloje Street, Ilorin, 23/8/2022. During the Military regime, the basic health centres were supplied drugs and uniform on consistent basis. During that period, treatment was free of charge. Pregnant women only came with Dettol, pad, Olive oil, and jik to disinfect the labour room's instruments and toilet. Those that couldn't afford all others were only required to bring jik alone to clean and disinfect the toilets.
12. Oral interview with Alhaja Fatima Musa, retired Deputy Chief Community Health Extension Officer. Ipata Oloje Street, Ilorin, 16/7/2021. The supply of these basic essentials stopped and health workers unofficially started contributing money among themselves to buy them in stock.
13. Oral interview with Alhaja Oganija, Matron and Director of Nursing Service (DNS), Basic Health Centre, Ipata Oloje, Ilorin, Kwara State. 12/03/2022. The bulk of the services of the basic health centre within the time frame of this research were sponsored by foreign donors and non-governmental agencies. However, the implementation of the Basic Healthcare Provisional Funds in Kwara State in 2021 was a success story and a hope for reclaiming the lost glory in Primary health care sector in Nigeria. Henceforth, the fund catered for health insurance of people in age 60 and above and paid for casual staff and community volunteers among others.
14. Oral interview with Mallam Babatunde Elere, Health Educator. Basic Health Centre. Ipata Oloje, Ilorin Kwara State. 02/03/2022.
15. Oral interview with Alhaja Fatima Musa, retired Deputy Chief Community Health Extension Officer. Ipata Oloje Street, Ilorin. 16/7/2021.
16. Oral interview with Alhaji Ibrahim Salu, former Vice Chairman. Ilorin West Local Government, Orelope Street, Odota. Ilorin. 23/6/2022. The ulterior motive behind the centralization of the salary payment of was to place a ban on employment of local government employee, so as cut down funds for salaries in the joint allocation supervised by the Kwara State Government.
17. Ilorin West Local Government of Nigeria. Summary of Total Recurrent Budget (Personnel and Overhead). Proposed Budget. 2014.
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20. Oral interview with Mrs Olu Olubunmi, Retired Director of Nursing Service (DNS). General Hospital Ilorin. Ilorin. Kwara State. 22/4/2022.
21. Oral interview with Mr. Hassan Afeez, Auxiliary Nurse and Director. Aisha Patient Medicine Store. Sakasasa Street, Odota Area. Ilorin, Kwara State. 14/2/2022. Some



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medicine store owners cum birth attendants rented apartments very close to their stores. Some went to the extent of renting face-me-and-face-you rooms, and operate their maternity homes in the same building with other tenants and occupants, sharing the same toilets and bathrooms.

22. Olaleye, J.B. et al. land Use and Land Cover Analysis of Ilorin Emirate between 1986 and 2006 using Landsat Imageries. *African Journal of Environmental Science and Technology*. April, 2014. Vol. 6(4): 189-198.
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24. Tahmina Begum, et al. 2017. Indication and Determinants of caesarean Section Delivery: Evidences from a Population-Based Study in Matlab, Bangladesh. *PLUS ONE*. 2017. 12(11). <http://doi.org/10.1371/journal.pone.0188074> Accessed on 15/04/2022.
25. Oral interview with Alhaja Ibrahim Monsurat, Traditonal Birth Attedant, Elere Compound, Ubandawaki Street, Pakata Area, Ilorin, Kwara State. 27/3/2022. It is a common belief among the people that the traditional birth attendants and the faith based maternity homes has the spiritual prowess to monitor the progress of pregnancies and protect the mother and fetus against evil spirits. Visions were seen commanding the pregnant women to only seek spiritual maternity care in the specified church.
26. Oral interview with Mrs Abosede Ruth, a Faith Based Midwife, God the Winner Chapel Annex, Agunbelewo Area, Ilorin, Kwara State.
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28. Oral interview with Mrs Kudirat Maruf, a trader and victim of casual birth morbidity, who has just undergone corrective surgery at the General Hospital Ilorin, Kwara State. 4/2/2022.
29. Oral interview with Dr. AbdulMujeeb Biliaminu, a House Officer at the Maternity Ward, General Hospital, Ilorin, Kwara State, Nigeria. 29/3/2022. The side effect of the herbal concussion administered to pregnant women during pregnancy resulted in these morbidities and mortalities. Lack of appropriate measurement of these herbal mixtures served as one of the major perpetrators of side effects and maternal fatalities.
30. Oral interview with Dr. AbdulMujeeb Biliaminu, a House Officer at the Maternity Ward.
31. Oral interview with Mrs. Dorcas Mary, a Nursing Sister at General Hospital Osogbo, Osun State, Nigeria. 11/2/2022.
32. Oral interview with Dr. Abdullah Musa, Senior Registrar, Department of Obstetrics and Gynecology, University of Ilorin Teaching Hospital, Ilorin, Kwara State, Nigeria. 10/4/2022.

33. Oral interview with Dr. Abdullah Musa, Senior Registrar, Department of Obstetrics and Gynecology.
34. Oral interview with Dr. Abdullah Musa, Senior Registrar, Department of Obstetrics and Gynecology.
35. Oral interview with Dr. Abdullah Musa, Senior Registrar, Department of Obstetrics and Gynecology. Two years is the normal time to replenish the nutrient of the mother of a new baby to avoid anaemia. Most women that patronized and undergone birth delivery in these casual birth homes lacked this information, and naively engaged in repeated pregnancies which made them vulnerable to mortality and morbidity arising from anaemia. Lack of facilities to detect problems associated with anaemia in these casualized birth delivery clinic increases the mothers' health risk to lifetime morbidities.
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39. *Daily Trust Newspaper*. "Patients Laments Doctors' Negligence in Caesarean Delivery". <http://ilorin.info/fullnews.php?id=30385> Accessed on 16/4/2022. Patients lamented they had to pay for the correction of these errors committed by these quack doctors. One of such that occurred in Jebba had to undergo three operations in four months. After the first operation in Jebba, the second one was conducted to correct the fistula, and the third for appendix. All those three were conducted within four months which costs huge amount of money and pants of blood.
40. This information was sourced from a collection of interviewees residing in locations of these epicenters of quackery, those that had issues with these hospitals in the past and professional medical practitioners. The researcher found out that the consequences of the quackery in private hospitals was not limited to maternal issues alone; it cut across other health stratas. Most interviewees are members of Ilorin Emirate community. They pleaded anonymity due to the professional ties between them and the owners of these hospitals.