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TOWARDS ACHIEVING THE HEALTH MILLENNIUM DEVELOPMENT GOALS IN NIGERIA: STRATEGIES TO ACCELERATE PROGRESS

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Abstract

Nigeria is not on track to achieving the health Millennium Development Goals (MDGs) by the year 2015. This paper emphasizes that health MDGs may not be achieved if the imperatives of strategies such as community participation, inter-sectoral linkages and interventions, reduction of inequality and poverty, and health promotion are not employed. It is hoped that government's concerted efforts towards application of these strategies will put Nigeria on track to achieving the health MDGs.

Keywords: Millenium Development Goals, strategies, progress

INTRODUCTION

The world is a global village of interconnected threats and opportunities. "It is like the human body; if one part aches, the rest will feel it, if many parts hurt, the whole will suffer". Resource limited countries constitute these "many parts" of the global organization. The character and nature of their health development should therefore be a major concern of all nations irrespective of political, ideological, or economic orientation.

This realization has always provided the impetus for global consensus in setting health development goals to address health challenges, otherwise, a nations health challenges can jeopardize global health and development.

In the 1970s alternative ideas and methods were considered and tried to address failures of existing health services (Newell, 1975; Djukanovic and Mach, 1975). Also, within this period and in the 1980s, the member nations of the World Health Organization (WHO) pledged themselves to an ambitious target to provide health for all by the year 2000, that is, the attainment of a level of health that will permit all peoples of the world to lead a socially and economically productive life (WHO, 1981).

By the year 2000, the health development challenges were more daunting than they were in the 1980s. Therefore, in September 2000, the 189 member states of the United Nations including Nigeria unanimously adopted the Millennium Declaration, which outlined eight key development challenges (MDGs). The fourth to sixth goals are to reduce child mortality, improve maternal health and combat HIV/AIDS Malaria and other diseases respectively. There are targets

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for these goals that should be monitored through a set of twelve indicators (Table I). The deadline for delivery is 2015 (Millenium Declaration, 2001).

More than 70 percent of Nigerians live on less than US $1 per day (UNDP, 2005) impairing their abilities to afford basic health care. Nigeria's under-five mortality rate (U5MR) conservatively at 217 per 1000 birth is almost twice that of the Democratic Republic of Congo at 108, more than twice that of Ghana at 95 and about 31 times that of Britain at 7 (World Bank, 2007). The Nigeria 2005 average national maternal mortality ratio estimate by the United Nations inter-agency was 1,100 deaths per 100,000 live births and the lifetime risk of maternal death at 1 in 18. When viewed in global terms, the burden of maternal death is brought into stark relief: approximately 1 in every 9 maternal deaths occur in Nigeria (UNICEF, 2008).

South-African has the largest population of HIV patients in the world, followed by Nigeria and India (UNAIDS WHO, 2007).

Based on 1990-2005 trend analysis, Africa will perform poorly on health MDGs if these trends continue (World Bank, 2007). Not one Sub-Saharan African country is on track to meeting the health MDGs. For example, Nigeria requires 10.1 annual rate of reduction of U5MR to have sufficient progress towards achieving MDG targets but the observed annual rate of reduction is just 1.2 (UNICEF, 2008).

Will the pledge to Millennium Declaration not end up the way of the ambitious Alma-Ata declaration which called for acceptance of the WHO goal of health for all by 2000 AD proclaiming Primary health care as a way to achieving health for All?

This is my worry and the overriding impetus for this paper, which attempts to offer strategies to accelerate progress towards achieving the health MDGs targets.

COMMUNITY PARTICIPATION

In 1941, Henry Sigerist, the medical historian stated that "The people's health ought to be the concern of the people themselves. They must struggle for it and plan for it. The war against disease and for health cannot be fought by physicians alone. It is a people's war in which the entire population must be mobilized permanently" (Stigerist, 1941). Communities should be full partners on issues concerning their health.

Community participation is a cumulative process through which beneficiaries develop the managerial and organization capacity to increase the control over the forces and decision that affect their lives (Quick *et al.*, 1997). A community's full participation in the decision-making process implies the definition of health development in terms of local needs and priorities; mobilization of community economic, human and organization resources; creation of mechanisms that help people increase their access to information, knowledge, and skills, voice their opinions and make their goals and priorities known" (Quick *et al.*, 1997). Differences in the culture and attitudes of communities dictate the importance of community tailored approaches especially on health issues. The fact that it is in communities and household that people take decisions about family size, sanitation, use of resources, how to use medicine, choice of health care provider and facility, government health programme to accept etc, projects and programmes aimed at improving health care may not achieve their objectives and ensure sustainability unless there is genuine participation of the communities.

In Nigeria, communities are not sufficiently considered as partakers on

health issues. Generally, public health programmes and services are provided on a take-it-or-leave-it basis. Usually, secondary benefits and complementary services are not considered in the sitting of health projects. Health institutions are set up for the convenience of the providers and available services dictated by the priorities of donor organizations rather than the health needs as seen by the community or recipients of the service (Brew-Graves, 1990). Public health institutions in Nigeria are weak (Akinsete, 2008). Efficiency, public accountability, mobilizing complementary resources, quality of services and user confidence can be improved through community participation in management and finance. When communities are not involved in health project planning, people are denied their basic rights, the linkages between health services and local perception of needs, confidence in their abilities to change their situation and better their health status, and the benefits of local skills and resources. Consequently, communities see these projects as not theirs and the objectives of such projects are usually ill achieved and services unsustainable.

Nigeria was a signatory to the Bamako initiative (launched in Bamako, Mali in 1987) which was a response to the deterioration of health systems in resource limited countries during the 1970s and 1980s. It aimed to ensure affordable essential health services for the majority of the population and involve the community to foster better health.

Today, all linkages to health in Nigeria have not been effective because the Primary Health Care (PHC) system is weak, uncoordinated, and the benefits of cross-government synergies are lost. This has hindered actions in improving Nigeria's health indicators. For example, in voluntary testing for HIV infection, why tell a person he is sero-positive when the PHC support cannot provide the essential back up.

Activities at the PHC level must ensure affordable health services for the majority of the population and greater decision making power should be delegated to the communities. Communities become active partners whose voices count and who foster better health through community financing and co-management of health services, and promotion of behaviour changes at the household level. When communities are involved PHC facilities are seen as their own and improvement in manpower, supplies and infrastructure are reasonably guaranteed on a sustainable basis. This is a sure way to improving Nigeria health indicators.

INTER-SECTORAL LINKAGES

Health is a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 1948). This paints a positive picture of health as complete well-being in which a preoccupation with disease is replaced by a recognition of the interaction between the individual and the environment in determining health. This signals the move away from a disease or biomedical model of health to the holistic model emphasizing the interaction between biological processes, psychological and social factors. The holistic approach implies that all sectors of society have an effect on health, in particular agriculture, food, industry, education, housing, public works, communications and other sectors (Park, 1997). Also, health is partly determined by social factors such as living conditions and personal habits (e. g. smoking) rather than just disordered biology. Therefore, achieving the health MDG targets by 2015 would require multi-sectoral approaches.

The importance of inter-sectoral interventions and coordination is not new in the health development literature (Hicks and Streeten, 1978; Hicks, 1979), yet it is often down–played when designing health projects in Nigeria. In Nigeria, for instance, not enough publicity has been undertaken to explain that AIDS is not only a health problem but also a societal problem that can have very hard social rooting; and social, political and economic causes and consequences which can only be solved through a multi-sectoral approach (WHO, 1982). MDGs will be useful tools only if seen as broad objective with multi–dimensional interventions. To be real, it will be counter–fruitful if the goal of achieving two– third reduction in under–five mortality rate (U5MR) for instance, is equated with spending on child health. Nigeria's U5MR depend crucially on the availability of clean water. Also, the one unit nature of mother and child relationship dictates clear gains in maternal and child interventions (Park, 1997). Proper nutrition of the mother prevents low birth weight babies. Educated women generally do not have early pregnancies; have better access to information on personal hygiene and care of their children, make better use of health services and are able to space their pregnancies. She also appreciates the importance of using bed nets to prevent malaria, hand washing with soap to prevent diarrhea and other preventive measures of avoiding infections such as tuberculosis and human immunodeficiency virus (HIV).

The Human Development Index (HDI) is a composite indicator. It covers three dimensions of human welfare: income, education and health. It provides a measure of human development that goes beyond income and it is a barometer for changes in human well – being. Progress in health development requires advances across a broad front: losses in human well fare linked to life expectancy for example, cannot be compensated by gains in other areas such as income and education. Moreover, gains in any one area are difficult to sustain in the absence of overall progress. For example, poor education can constrain economic growth and performance in health, and slow growth reduces the resources available for social investment (World Bank, 2007).

Nigeria is ranked very low in HDI (118 globally) because its modest achievement in income growth is eroded by poor scores in life expectancy and minimal increase in school enrolment (World Bank, 2007). Achieving the health MDGs in Nigeria by the year 2005 will be a mirage if the core role of infrastructure- particularly water, sanitation, transport and electricity - are ill appreciated.

Better transport contributes to easier access to health care as well as easier staffing and operation of health institutions (Brenneman and Kerf, 2002). Also improved transport policy can reduce the emission of carbon IV oxide which worsens acute respiratory infections and lead to pollution, both of which are particularly harmful to children. Electricity is the lifeblood of any economy; it is essential for the provision of health care and functioning of health institutions. Availability of electricity reduces indoor air pollution, accidental burns from adulterated fuel and death from carbon II oxide from generators. Free access to piped water (apart from its obvious benefits) especially in rural communities will free girls to attend school, be educated mothers and contribute to promotion of better health. Measures should be instituted to ensure wide spread availability of sustainable infrastructure. For example, in Argentina, privatization of about 30 percent of the countries municipal utilities covering 60 percent of the country's population resulted to 5 to 9 percent fall in child mortality

due to infectious and parasitic diseases (Galiani, 2002).

Multi-sectoral interventions or linkages are keys to achieving health MDGs and doing so at potentially lower cost. The opportunity it offers must be explored if Nigeria is to be on track to achieving the health MDG target by 2005.

POVERTY AND INEQUALITY

Health is an important component of Human Development Index and Poverty Index. The poor health indicators of most resource-limited settings including Nigeria are rooted in inequalities.

Health MDGs are distribution neutral, requiring that progress in such goals should be measured for all of the society and not just in the aggregates. In other words, assessments of progress in health should not be based on national averages but the magnitude experienced by the most disadvantaged. This is underlined by the fact that opportunities that shape the distribution of income, education, health and wider life chances in any society are not randomly distributed. In Nigeria, disparities hampering progress in health are systemic and reflect complex hierarchies of advantages and disadvantages that are transmitted across generations and they reflect public policy choices. Poverty leads to outcomes which expose the poor to poor health and diseases. For instance poverty especially rural poverty and absence of access to sustainable livelihood are factors in labour mobility especially for young men and women. These mobile populations are isolated from traditional, cultural and social networks, and in the new environments and conditions often engage in risky sexual behaviours with obvious consequences in terms of HIV. In rural Nigeria many of the poorest are women who often head the poorest of households. Inevitably such women will often engage in commercial sexual transactions, sometimes as commercial sex workers but more often on occasional basis, as survival strategies for themselves and their dependants. The effects of these behaviours on HIV infection in women are only too evident, and in part account for the much high infection rates in young women who are increasingly unable to sustain themselves by other works in either the formal or informal sector [21].

Perinatal transmission of HIV is largely preventable through appropriate access to drugs [e.g. Zidovudine (AZT)] but these drugs and the necessary infrastructure for their delivery are more or less unattainable for most Nigerian women due to poverty.

Also, to prevent transmission through breast milk requires the ability to buy baby formula and access to clean water, plus an understanding of why these changes in practice are needed. Neither clean water nor the income for purchasing formula are available to the poor, so they are unable because of their poverty to adopt a form of prevention known to be successful as a means of limiting HIV transmission. This problem is resolvable through relatively inexpensive programme activities backed up by community mobilization to ensure support to families. There are therefore no good reasons why action in this area are not being undertaken by governments, non-governmental organizations (NGOs) and donors.

Inequality in service use adds to vulnerability. For instance, the poorest women are more likely to be malnourished and less likely to take advantage of services because they are unavailable, unaffordable or of inadequate quality. Beyond service provision, deeper gender inequalities exacerbate the problem. Estimates suggest that birth spacing could reduce death by 20% percent in India and 10% in Nigeria, the countries with the

highest neonatal mortality rates. Lack of control over fertility, which is linked to imbalance in power within the household and beyond, is central to the problems (World Bank, 2007).

Women in poor households are less likely to receive antenatal care and have their births attended by a trained medical assistant. In Nigeria, over 66 percent of births occur at home (NPC, 2004). Illiteracy especially among women and discriminatory cultural attitudes and practices are barriers to reducing high maternal mortality ratios. A study at the Jos University Teaching Hospital showed that nearly three-quarters of maternal deaths occurred among illiterate women, the mortality rate among women who did not receive antenatal care was about 20 times higher than those who did and the Hausa-Fulani women accounted for 22 percent of all deliveries and 44 percent of all deaths (Wall, 1998). Child marriage and high rates of adolescent birth are common place across Nigeria, exposing girls and women of reproductive age to health risks and deaths.

Living in rural area is in many countries including Nigeria, a maker for disadvantages; poverty rates are higher and access to health services is low. Rural communities account for over 70 percent of Nigeria population and rural poverty increased from 22 percent to 69.9 percent, while urban poverty increased from 7.6 to 55.2 percent between 1980 and 1996 (FOS, 2004). In the year 2004, poverty rates in rural areas, estimated at 64 percent are roughly 1.5 times higher than urban rate of 43 (Wall, 1998). The Nigerian rural-urban divide is equally marked in access to basic services. Only about half the population had access to safe drinking water (40% in rural and 80% in urban areas)

More than 90 percent of rural population depended on forest for livelihood and domestic energy sources. Rural household spent an average of 1.5 hours a day collecting water and fuel woods with household members walking an average of one kilometre a day to collect water and fuel wood (NEEDS, 2004).

Nigeria is a good example of the central lesson that the link between income and social progress is not automatic. Nigeria has failed to convert rising income into rapid decline in poverty. This underlines the fact that economic growth is not “open sesame” to social progress; the efficiency with which available resources are used, the distribution of wealth and improvement in general socio-economic conditions including infrastructure development are equally important.

Given these complex realities, inequalities in health can be reduced using strategies that ensure sustainable distribution of health resources and other linking sectors such as infrastructure and education in a just and fair way with no one being deprived the benefit of adequate health. For instance, interventions such as provision of oral rehydration therapy, drugs, insecticide-treated nets for preventing malaria and antenatal and obstetric care can have strong impact on reduction of child mortality. These interventions can be provided on a low-cost basis through trained health workers and local communities. In Nigeria, the precise intervention priorities should vary by communities and there is no single solution but the common problem is one of low coverage of services, high levels of inequality linked to poverty and neglect of neonatal mortality in public health.

Nigeria does not need high technology interventions to reduce neonatal mortality. Sweden at the end of the nineteenth century and the United Kingdom after 1945 achieved rapid declines in neonatal mortality with the introduction of free antenatal care, skilled attendance at child birth and

increased availability of antibiotics. Resource-limited countries such as Malaysia and Sri Lanka have similarly achieved steep declines in neonatal deaths through simple home-based; district-level interventions supported through training for health workers and midwives and publicly financed provision (World Bank, 1998). Also, Nigeria may lack the institutional capacity to scale up measures towards achieving the health MDGs, but many poor countries have achieved rapid advances by using institutional structures creatively. Egypt has sustained one of the fastest declines in child mortality rates in the world since 1980. Bangladesh, Hunduras, Nicaragua and Vietnam have also achieved rapid progress. In each case decentralized district – level programmes have integrated child health and maternal health programmes ---- including immunization, diarrhea treatment and antenatal care ---- into health service delivery. They also invested in training health workers and midwives and in targeting vulnerable populations (UNAIDS WHO, (2007).

Nigeria must focus more on poverty reduction strategies aimed at addressing the structural causes of high prevalence of HIV/AIDS, increased malaria incidence, high mortality linked to low status of women, inequalities in access to health care and failure to prioritize child and maternal health.

HEALTH PROMOTION

The biomedical model of health emphasizes failed and failing health and the identification and treatment of disease process rather than the promotion and maintenance of health. Health promotion is particularly important in a resource limited country like Nigeria where over 70 percent of the population can hardly afford health care cost and there is near absence of a National mechanism for health promotion (Wall, 1998). The process of promoting health is not directed against any particular disease, but strengthens the people's health through a variety of interventions that include health education, environmental modifications, nutritional interventions and life style and behavioural changes (Quick *et al.*, 1997).

The main objectives of health education are to inform, motivate and guide people into action. It is cost effective and large number of diseases could be prevented with little or no medical intervention if people were adequately informed about them and encouraged to take necessary precautions on time. People should be informed that disease is not a normal ingredient of daily life. With adequate and effective information about health and disease, the barriers of ignorance, prejudices and misconceptions melt away (Park, 1997). Specific health promotion efforts reduce vulnerability to disease. For instance, there is no vaccine to prevent HIV infection and no cure for AIDS. But it is possible to protect yourself and others from infection. This means that people should be educated about HIV and the need to avoid behaviour that allow HIV-infection fluids --- blood, semen, vaginal secretion and breast milk ----- into their bodies.

Abstinence- and comprehensive-based sex education approaches should be used to ensure that people avoid infection with HIV and other sexually transmitted infections

People must also be motivated using learning experiences that favourably influence bad habits and ways of living such as family planning, polluting water, outdoor defecation, cigarette smoking, alcoholism and addiction. Health education and communication personnel need to guide and help people use health resources and adopt and maintain healthy life style. Education effort should target the

general public, priority groups, community leaders and decision makers and must be target specific to be effective. For instance poor households typically have few if any financial or other assets and are often politically and socially marginalized. These conditions of social exclusion increase the problem of reaching these populations through programmes aimed at changing sexual and other behaviours. Massages may be understood but are often considered irrelevant and inoperable given the reality of their lives. Indeed, to take the long view in sexual or other behaviours is antithetical to the condition of being poor. For the poor it is the here and now that matter, and policies and programmes that recommend deferral of gratification will, and do, fall on deaf ears (Collins and Ran, 2007). More generally, it is the absence of effective programmes aimed at sustainable livelihoods which limit the possibilities of changing the socio-economic conditions of the poor. But unless the reality of the lives of the poor are changed they will persist with behaviours which expose them to infections and death, thus worsening the Nigeria health indicators

Environmental modification underlines the provision of safe water, effective sanitation, improvement of housing and electricity (World Bank, 2007). The demand on vaccines and chemotherapeutic drugs will decrease if many infectious diseases are controlled through environmental modification.

Nutritional intervention involves improving food distribution, nutrition of venerable groups, food fortification and child feeding programmes (Quick *et al.*, 1997).

Most diseases affecting Nigerians especially mothers and children are preventable and can be reduced substantially through cost-effective and target-specific health promotion.

CONCLUSION

In Nigeria, most unfavourable health indicators arise from inequities in health care services exacerbated by deeper gender inequalities. The thinking must change from health care for the people to health care by the people. Sustainable health services result if communities are involved in the planning, implementation, utilization, operation and evaluation of health projects and programmes. To be effective, the health services must reach the social periphery, equitably distributed, accessible at cost the country and community can afford and socially acceptable.

Multi-sectoral linkages are keys to reaching the health MDGs, and doing so at potentially lower costs. In fact, health MDGs should be seen as broad objectives requiring multi-sectoral interventions and consequently enjoy the benefits of cross-sectoral synergies. Our hospitals ought not to be only disease oriented but must also have responsibilities in the field of preventive medicine and health promotion. The war on health MDGs is won and lost at the communities, therefore, adequate mechanisms must be put in place to ensure equity in the delivery of societal services; selection of leaders must be based on democratic principles and public interest, not on political influence and patronage or nepotism. Policy making must be based on democratic dialogue and consultations rather than the use of discretionary power by the political authorities; and mechanisms must be instituted to promote accountability.

Improving the health systems along these strategies have the potential to put Nigeria on track to meeting the health MDGs, otherwise, it will go the way of under achievements in Health for All by the year 2000 and primary Health care programmes.

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