HEALTH BILL AND MDGS 4, 5, & 6

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Worldwide, every year about 500,000 women die in childbirth and over a million children under the age of five die mostly from preventable and treatable diseases, with Africa accounting for the highest burden of this malady. Maternal and child mortality is not an uncommon event in several parts of the developing world, where a woman dies every minute in childbirth and more than 25,000 children die every day[1.2].

Nigeria is the most populous country in Africa with an estimated population of 150 million including 75million children. The child and maternal mortality rate of this country is very significant and has implications for the attainment of the MDG 4,5 and 6[3].

It has been noted that Nigeria is lagging behind in achieving universal health interventions and will unlikely meet the target for the MDGs. According to the UNICEF executive director, Ann Veneman, "Nigeria continuous to record unacceptably high maternal, newborn and child mortality"[3]. Nigeria ranks as one of the 13 countries in the world with the highest maternal mortality rate and is still not listed among the 10 countries seen to have made rapid progress to meet the MDG goals[3,4].

Maternal mortality rate in Nigeria is about 840/100,000 live births. Annually, an estimated 52,900 Nigeria women die from pregnancy related complications out of a total of 529,000 global maternal deaths. This means that Nigeria contributes about 10% of the world maternal mortality figures.[3.4.5] A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13 compared to 1 in 35 in Ghana and 1 in 2800 in developed countries[4,5]. Only 58% of Nigeria women receive ANC during pregnancy and, skilled birth attendants attend to only about 39% of these deliveries.

Till date, Nigeria is second on the maternal mortality rate in the world with about 144 girls and women dying everyday from complications of pregnancy and childbirth. According to the survey conducted in Feb, 2010, the records stand at between 165 per 100,000 live births in the south-west and 1549 per 100,000 live births in the north east.

An estimated 250,000 newborns die annually in Nigeria with the neonatal mortality rate of 48 per 100 live births.

Just as with the maternal mortality, the neonatal mortality rate in Nigeria has wide geographical variation, the highest rates are seen in the north east and North West zones of the country, the lowest rate noticed in the south west and south east. It is said that most of the causes of these deaths are either preventable or treatable.

This unhealthy trend has become a matter of great concern, calling for concerted approach for all and sundry. The millennium development goals (MDGS) by the global community focus attention, resources and actions on improving the wellbeing of all people. Three of the goals (MDG 4, 5 and 6) were to reduce the childhood mortality rate and maternal mortality ratio, by two thirds and three quarters, (75%), amongst others, respectively between 1990 and 2015[2,3].

The state of maternal, newborn and child health is an important indicator of a nation's health care delivery system and level of society's development. Previous efforts to meet the MDGs on the reduction of maternal and child mortality in Nigeria have shown only marginal reductions in the last five years, making the MDGs' target by 2015 clearly unachievable using current strategies alone

Strategies for Reduction of Maternal Mortality

There are three major strategies to prevent maternal mortality and morbidity. These interventions are most effective when implemented as a total package. These strategies include **family planning**, **skilled attendance at birth** and **emergency obstetric care**.

Family planning helps in the reduction of unwanted pregnancies and thereby reduces unsafe abortions. It allows women to properly space pregnancies and avoid pregnancies at too young or too old an age. Reducing the sheer number of pregnancies means fewer pregnancy related deaths. It is estimated that meeting the existing demand for family planning services alone would reduce pregnancies in developing countries by 20% and maternal mortality and injuries by that much or more.

Skilled Attendance At Birth

Most obstetric complications occur at the time of labour and delivery. It takes a professional to swiftly recognize life-threatening complications and to intervene in time to save the mother's life. A skilled attendant is a professional midwife, nurse or doctor able to supervise normal deliveries, quickly recognize and manage complications and refer them appropriately. It has been estimated that if 15% of births are attended by doctors and 85% of them are attended by midwives, then the maternal mortality will be adequately reduced. Skilled attendance at birth has been one of the most obvious common programming techniques in countries that have been successful in reducing maternal mortality.

Emergency Obstetric Case

Emergency obstetric care refer to a series of signal functions performed in health care facilities, that can prevent the death of a woman experiencing complications of pregnancy. The emergency obstetric care functions are often divided into two categories: Basic emergency obstetric care (EMOC); which can be provided at a health centre by a nurse, midwife or doctor and comprehensive EMOC, which usually requires the facilities of a hospital with an operating theatre and facilities for blood transfusions. WHO recommends that for every 500,000 people, there should be at least 4 basic EMOC facilities and at least one comprehensive EMOC facility. This ensures that the health facilities are available and accessible by the people.

Useful process indicators for maternal mortality include the percentage of deliveries attended by skilled professional the number of facilities offering emergency obstetric care, their geographic distribution, the percentage of women with complications treated in EMOC facilities, the caesarean section rate and case fatality. The indicator selected to measure progress against millennium

development goal is the proportion of births attended by a professionally trained and skilled attendant.

The Health Bill and MGDS

Human right-based approach to maternal mortality is being advocated to take priority in the design and implementation of maternal mortality programmes. Since most maternal mortality is avoidable, human right principles can be called upon to denounce its persistence and to promote an end to this injustice through universal access to skilled care during pregnancy and childbirth.

Human right approach encourages respectful treatment of patients at facilities. At the policy level, human rights principles can inform dialogue and policy making for health sector reform.

To this end the National Health bill will provide the framework for regulation, development and management of a national health system and set standards for rendering health services in the country. For the first time, the health issues of the country are being encapsulated in a legal document making it a human rights issue. It provides the legal framework for the management of health resources giving it a wholistic approach to matters concerning the health of the citizenry.

Central to the achievement of MDG 4,5, & 6 is the provision of skilled professional attendance in pregnancy and delivery.

Nigeria has about 26 teaching hospitals, 9 federal medical centres and several other specialist hospitals, numerous schools of nursing and midwifery that produce several hundreds of doctors, specialists in different fields, nurses and midwives, and yet It is estimated that less than 50% of Nigerian pregnant women receive ANC and less than 38% have skilled attendance at birth[6].

However, must of these skilled manpower in the health sector are only found in state capitals and cities. In most cases the skilled personnel cannot be found beyond 20km radius of the urban centres to the detriment of the rural communities where most of the worst morbidities and mortalities occur. There is therefore a mal distribution of skilled health professionals[6].

Maternal mortality therefore reflects the distribution of these skilled health workers with the worst found in the northeast geopolitical zone, where because of the current challenge of insecurity migration of these skilled personnel to other areas deemed to be safer thereby compounding the already bad situation.

Part V of the Health Bill seeks to address the issue of human resources for health. It seeks to ensure the following

1. Provision of appropriately trained staff at all levels of the national health system to meet the population health care needs.
2. Adequate distribution of human resources
3. Adequate distribution of health care providers and health workers
4. Prescribe strategies for the recruitment and retention of health care personnel within the national health system and from anywhere outside the country.

Section 41 subsections 1 of the health bill provides that “the national council shall develop policy and guidelines for, and monitor the provision, distribution, development and utilization of human resources within the national health system”.

This is a very welcome development. It is therefore hoped that when these policies and guidelines are in place it will ensure even distribution of the skilled health professionals especially to those places that they are most needed. It is hoped that these policy and guidelines will be supported and the political will shall be there to ensure that they are fully complied with.

The strategies for the recruitment and retention of health care personnel within the health system, and from anywhere outside the country should include provision of enabling working environment i.e. good housing, security, hospital equipment, and other incentives, that will motivate these health professionals to be retained in the rural areas.

Equally very important is the location of these health care facilities. In a situation where hospitals are sited for political reasons negates the principle of equality before the law. Every citizen has the right of access to good and qualitative health care irrespective of his or her gender, creed and social status. When health facilities are easily accessible and affordable with highly trained personnel manning these facilities will definitely put Nigeria on the pathway of the fulfillment of MDG 4/5.

The policies and guidelines should also be unambiguous as to what happens to the health professional that refuses posting to the rural areas. The law should come out clearly to state the punishment that shall be given to such officers who refuse posting to such areas. Before doing this the government must ensure that the conducive working environment is provided for such areas such as road, electricity etc. This will help in reducing what I call 'pseudo scarcity' of health personnel. Equally important are clear guidelines to check brain drain in the health sector.

Another area where the national health bill will help in the achievement of the MDG 4/5 is in the area of provision of emergency healthy care services. Part III, section 20 sub section one states that; “a health care providers, health worker or health establishment shall not refuse a person emergency medical treatment”.

One of the three strategies for the reduction of maternal mortality is the provision of emergency obstetric care in basic and comprehensive health centres. These are sets of emergency interventions that are offered to women who develop complications during labour and delivery. These include provision of oxytocics, antibiotics, anticonvulsants, manual removal of the placenta, and manual vacuum aspiration for the basic care. The addition of blood transfusion services and caesarean section gives the comprehensive emergency obstetrics care.

One area that has been a stumbling block to the provision of emergency services is the issue of financial deposits before treatment commences for such individuals. Refusal of emergency treatment for failure to pay financial deposit especially in the private hospitals has cost lives.

The law should come out clearly on this issue especially as regards obstetric, paediatric emergencies and RTA victims.

The provision in the law to establish a working partnership between the private and public health establishment is a step in the right direction.

Section 18C subsection 1 and 2 states that; “the minister shall prescribe mechanisms to ensure a coordinated relationship between private and public establishments in the delivery of health services”.

Sub section 2 – "The Federal Ministry, any state ministry or local government may enter into agreement with any private practitioner, private health establishment or non governmental organization in order to achieve any objective of this bill".

If this provision of the law is implemented, the federal government, states and local governments are at liberty to network with the private and non-governmental organizations to facilitate the delivery of emergency medical treatment to people in need of emergency medical services.

These agreements should be in the form of a written memorandum of understanding (MOU) with legal backing to check default on either party. Such MOU shall be in the provision of trained skilled medical personnel, provision of emergency drugs, blood transfusion services and adequate referral agreements as captured in section 17 sub sections 2 of the bill. This will go a long way reducing maternal and child mortalities.

Matters Arising

The health bill takes a human right-based approach to the health of the citizens; it does not identify and address specifically the very serious health issues like maternal and child mortality. Therefore no specific provisions are made in the bill on how to tackle this menace that has given Nigeria a negative image in the international health fora.

The bill does not address the serious social, religious and cultural barriers, which prevent proper distribution and utilization of health care.

The health bill also fail to address or does not make provision for confidential enquiries into maternal health- the procedure for auditing maternal death in the community and health system.

It does not address specifically how the health facilities and trained personal should be distributed.

Maternal and child health care are complex and their indices provide insights into the effectiveness of the national health care delivery system.

Therefore modalities for the reduction of maternal and child mortalities in Nigeria should be addressed separately in a specific bill where all the dynamics involved are identified and addressed. Until this is done achieving the MDGs 4 and 5 will still be a mirage.

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