Reducing the Barriers to the Attainment of the Millennium Development Goals for Maternal Health in Nigeria
- *The Seventh Okoronkwo Kesandu Ogan Memorial Oration*

Benjamin C. Ozumba
Professor of Obstetrics & Gynaecology and Provost, College of Medicine, University of Nigeria, University of Nigeria Teaching Hospital, Enugu, Nigeria

Introduction
In September 2000, 189 Heads of States adopted the United Nations Millennium Declaration, which was thereafter translated into a roadmap setting out goals to be reached by the year 2015. The eight Millennium Development Goals (MDGs) build on agreements made at United Nations (UN) Conferences in the 1990s and represent commitments from both developed and developing countries. The goals range from halving global poverty and hunger to protecting the environment; improving health and sanitation, and tackling illiteracy and discrimination against women.

The intention is that almost all of these targets would be met by the year 2015. Unfortunately, while significant progress has been, and is being, made towards meeting some of the targets in many of the affected countries, progress is patchy, too slow or non-existent in some cases.

The eight Millennium Development Goals are listed hereunder:-

- Eradicate Extreme Poverty and Hunger
- Achieve Universal Primary Education
- Promote Gender Equality and Empower Women
- Reduce Child Mortality
- Improve Maternal Health
- Combat HIV and AIDS, Malaria and other diseases
- Ensure Environmental Sustainability
- Develop a Global Partnership for Development.

It is patently obvious that four of the Goals relate specifically to health. Specifically, the goal of Millennium Development Goals on maternal health aims to reduce maternal mortality by three quarters by the year 2015.

Safe Motherhood in Nigeria: Still Unsafe
The Safe Motherhood Initiative was launched in 1987 by a coalition of international organizations and Non-Governmental Organizations (NGOs). The term "Safe Motherhood" refers to a woman's ability to have a safe and healthy pregnancy, and delivery of a healthy infant.

Nigeria is the most populous country in Africa, with a population of approximately 140 million by 2006. Her reproductive health indices however rank among the poorest in the world. There have been increases in the rate of attended deliveries in South East Asia and North Africa. However more than 500,000 women die in pregnancy and child-birth each year and maternal death rates are 1000 times higher in sub-Saharan Africa than in high income countries. Indeed recent data published by UNFPA/UNICEF indicate that Nigeria now has the second highest rate of maternal mortality in the developing world[1].

By its endorsements of the Cairo Program of Action (1994)[2] and the Beijing Platform for Action (1995)[3], the Nigerian Government, alongside others, affirmed its commitment to promoting the reproductive health of Nigerians. In spite of this stated commitment however, it is extremely difficult to say there has been significant progress made in advancing reproductive health in Nigeria about a decade thereafter. This is hardly surprising given facts such as low levels of antenatal coverage but high fertility rates among women and even adolescents.

The Barriers
The International Federation of Gynaecology and Obstetrics (FIGO), in its 1994 World Report on Women's Health, concluded that improvements in women's health would require much more than better science and better health care. According to the World Bank, Africa is falling behind in the race to reduce, sharply by the year 2015, the number of deaths among pregnant women and among children under the age of five years. It says this situation is particularly distressing as many of the 'technologies' needed to improve health are available and affordable, and that even in countries with little money and few health facilities, sensible and systemic efforts to improve health can work.

State action is required to correct injustices to women[4]. These injustices are necessary to correct in order to attain the Millennium Development Goal for maternal health in Nigeria.

The 7th Okoronkwo Kesandu Ogan Memorial Lecture was delivered at the 40th Annual General Conference of the Society of Gynaecology & Obstetrics of Nigeria (SOGON) at the International Conference Centre, Abuja, Nigeria in November 2006.

The barriers against women's quest for sound maternal health include:

(a) ***Tradition, Culture and Religion***

The existence of misogynistic conceptions, beliefs and normative values in culture and religion fosters practices that provide institutionalized support for women's subordination and systemic discrimination against women. In a patriarchal society where women's role is subordinated to that of men and the purpose of women's lives is virtually confined to their reproductive functions, this being their main service to a society where men's interests reign supreme, it can only be expected that women's reproduction will be controlled by men. In context, these pervasive traditional, cultural and religious beliefs and normative values are used to supplant scientifically established evidence that many beliefs and practices relating to sex, sexuality and reproduction put women's health at risk. Female genital mutilation (FGM), early marriage, early and repeated child bearing, unequal female status and gender-based violence (GBV) are usually presented as part of our 'identikit' which must be preserved against the encroaching 'westernization' and 'globalization' of culture. These militate against maternal health.

(b) ***Inadequate Legal and Policy Framework***

Arguably, the major challenge in the area of inadequate legal framework is the conflicting values espoused by the law as it exists. Whereas Nigeria is a signatory to an array of international human rights instruments, which affirm, in clear terms, the aspiration of enhancing maternal health and rights, Nigeria also has an array of laws reflecting aspirations at variance or in direct opposition to what these international instruments espouse. For example, Nigeria has many customary laws that provide institutional support for practices such as early marriage, early and repeated child bearing, female genital mutilation (FGM), widowhood rites and inheritance practices that limit women's exercise of their reproductive choices and expose their health to injury. Even where statutes exist to outlaw some of these inimical customary and religious practices, historical evidence is that enforcement level is so low, suggesting only a half-hearted commitment on the part of the state and its agents.

Another major challenge is the complicit silence of the law in many areas where it should be expected that the law would directly and expressly intervene to secure the rights of the vulnerable. For example, there is no law to facilitate access to contraceptives against the backdrop of awareness that even health care providers exhibit various forms of prejudices that constrain user's access to health care, nor is there a specific law to respond to the confidentiality rights of individuals seeking reproductive health services. International instruments and documents usually require state parties thereto to take necessary steps to review and amend their laws to bring them in line with the standards and aspirations reflected in them. It is known that with the exception of a few states of the Nigerian Federation that have passed laws prohibiting female genital mutilation and widowhood rites, very little has been done to reform laws relating to sexual and reproductive health.

Law's complicity in compromising women's reproductive health is also evident in the status of Nigeria's laws on abortion. Nigerian Law restricts legal abortion to abortion carried out to save the mother's life only and criminalizes all other forms of abortion. The law does not only punish the person who carries out the abortion but the women on whom the abortion is performed, where she had consented to the abortion. Yet, this is a country where female fertility rates rank highly; there is no financial support for families from government and access to contraceptives is poor. Many thus resort to clandestine and unsafe abortions. Available statistics place deaths due to induced abortion at 40% of all maternal deaths.

A number of policy documents on sexual and reproductive health and rights have been adopted in the last five years, but commendable as this is, these do not constitute legally enforceable standards. They serve merely as administrative guidelines promising much but delivering little. They need a lot of governmental commitment to really make a positivr impact on maternal health in Nigeria. In the main, they call for genuine political will expressed in adequate provision of resources for programmatic interventions. This is yet to be done.

(c) ***Inequities in the Distribution of Access to Health Care***

As indicated from the situation of women's health in Nigeria, the bane of women's reproductive health is institutionalized denial of women's rights and lack of access to health care, including:-

- Lack of access to information about

diseases, especially disease of the reproductive tract and sexually transmitted infections (STIs)

- Lack of access to information about family planning and modern contraceptives and lack of access to safe, effective affordable and acceptable methods of family planning, which in turn impinge on the freedom to exercise informed choice in determining the number and spacing of their children and services needed to go safely through pregnancy and childbirth.
- Absence of reproductive health education and services for adolescents. Access to health care would include also access to the essential services recommended by the Safe Motherhood Initiative, namely community education on safe motherhood, prenatal care and counselling including promotion of maternal nutrition, skilled assistance during child birth, care for obstetric complications including emergencies, post-partum care, management of abortion complications and post-abortion care, family planning counselling, information and services. While women's access to health care during pregnancy is almost universal in the developed regions, an estimated 35% of women in all the developing regions of the world receive no care at all. The estimate for the African region is put at an average of 66%, although country-to-country variations are marked. In Nigeria, it is estimated that only 60% of women receive prenatal care at all [4]. The presence of a skilled attendant who can recognize and manage obstetric complications is essential to ensure that child birth is safe for both mother and child. Closely tied to this is access to a health facility where a woman can receive emergency care and interventions as needed. However, while the estimate for the developed regions is near universal, the average for Sub-Saharan Africa is put at 42% and the Nigerian average is a paltry 31%. While a woman's lifetime risk of death from pregnancy-related causes (maternal mortality) stands at 1 in 1,400 for women in Europe and 1 in 65 for women in Asia, it stands at an astronomical rate of 1 in 16 for women in Africa, and 1 in 21 for women in Nigeria.

Contraceptives have proven useful in helping couples avoid unwanted or mistimed pregnancies and reducing maternal mortality and morbidity as well as infant mortality. In particular, barrier methods of contraception have also been useful in protecting against the spread of STIs including HIV, which have long term and sometimes life-threatening consequences for women, yet access to, and use of contraceptives remain at very low levels and some of the reasons for this are non-availability, lack of knowledge, and high costs of some methods. These statistics demonstrate clearly that access to health care is indeed inequitable, with political geography (with its implications for differential in wealth and resources between the North and the South) largely accounting for the inequities. The new perspective informing the analysis of public health problems urge a rights-based approach to equity of access to health and distributive justice.

(d) ***Poverty***

It is apparent how easily individual and national poverty undermines the attainment of maternal health. Trends in maternal mortality demonstrate that poverty constrains choices that individuals and even nations/states make in terms of safe motherhood. It is pertinent to note that poverty does not stand alone in constraining the State in the context of Nigeria, in its ability to finance and allocate resources to maternal health programmes. Rather, the bane is poverty occasioned by corruption and bad governance.

(e) ***Ignorance/Lack of Education***

Widespread ignorance as a result of a absence of basic education, as well as lack of awareness and poor knowledge level in relation to maternal health can have a huge negative impact on the health status of women in the society. Many still believe that female genital cutting is effective in protecting against promiscuity and enhances sexual pleasure, while large segments of society deem the clitoris to be injurious to the baby as it passes through the mother's birth canal during delivery.

What Must Be Done

Education

Human Rights Education: The provisions of the Universal Declaration of Human Rights (UDHR underscore the importance of education in promoting respect for human rights. While human rights are proclaimed as universal rights, there is a clear recognition that they have not been universally accepted as such and education is considered key in de-briefing individuals, people-groups and even the state of beliefs, attitudes and values that

provide support for the non-respect for the human rights of all.

Basic Education: Studies have consistently demonstrated that basic education is critical in improving the individual's basic health status and in particular, women's education is critically influential in improving women's reproductive health. Both the Cairo Declaration and the Beijing Programme for Action (PFA) call for institutionalizing universal primary education by 2015 as well as for closing gender gaps in primary, secondary and higher education as part of the strategies towards improving maternal health. Although Nigeria can be said to have set the machinery in motion towards this end, there is so much more to be done. We are speaking of institutionalizing universal basic education more than 50 years after some other countries of the world and more than forty years after independence.

Sexual and Reproductive Health Education: It has been found that ignorance about sexuality, human reproduction, sexual health and reproductive health is a major contributory factor to the non-attainment of reproductive health and rights. We know well the massive wave of resistance in some quarters against publicly affirming the relevance of condoms, either for family planning, or for protection against sexually transmitted diseases.

Instituting and Adequate Legal and Policy Framework

It is submitted that there is an urgent need to affirm a constitutional right to health, to place the importance of health in proper perspective in Nigeria. The current approach merely includes health as a social objective for the state to avert societal dysfunction and foster communal wellbeing in promoting a social order founded on the ideals of Freedom, Equality and Justice[5]. This provision, however, is neither enforceable nor justiciable against the state. Unfortunately, our reality is that the state has paid more lip service in this direction than it has taken practical steps to improve substantially the health of Nigerians. Rife corruption and bad governance has been characteristic, so that available resources are neither judiciously nor maximally applied to protect the health of Nigerians. Nigerians should not have to die simply because they are Nigerians. States have to be challengeable and constitutional guarantees have always provided the necessary framework for challenging government's accountability to their people. There is need for a constitutional affirmation of an enforceable right to health as has been done under the South African Constitution.

Improving Health Care Delivery and Access to Health

The right to health includes the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health, an obligation to be discharged by the State. If we are to realize improved health care delivery in Nigeria, government must take urgent steps to bring to reality the proposed National Health Insurance Scheme.

Conclusion

In conclusion, it is to be noted that even with general economic growth and faster progress on the non-health MDGS, many regions will still miss many of the health MDG targets, including maternal health. It is important to look at measures such as committing increased resources to meeting the health-related MDGs, and using those resources more effectively in countries. For African countries, including Nigeria, the World Bank says increasing health spending is part of the answer to getting poor people the effective treatments they need, but it is not the whole story.

In countries without solid health and economic reforms in place, spending will have little impact unless money and services are targeted at people who need them most, such as the pregnant mothers in resource poor countries. On top of more spending, health systems also need to be modernized to better distribute life-saving drugs and treatments as well as family planning services. Medical staff need to be trained to offset the steady 'brain-drain' of doctors, nurses and other health care personnel to more affluent countries.

References

1. Okonofua F. Need to intensify Safe Motherhood interventions in Africa. *Afr J Reprod Health*, 2003; 7: 7-9
2. ICPD. *The Program of Action.* Adopted by 184 UN member States at the 1994 International Conference on Population and Development held in Cairo.
3. The PFA was adopted by 187 UN member States at the 1995 Fourth World Conference on Women held in Beijing China.
4. Cook, RD, Fathalla M. Advancing Reproductive Rights Beyond Cairo and Beijing. *Int Fam Plan Perspect,* 1996; 22: 115-121.
5. *Constitution of the Federal Republic of Nigeria*, Section 16; 1999.