THE POST-ACHIEVEMENT OF MILLENNIUM DEVELOPMENT GOALS (MDGS) OF 2015 ON MATERNAL HEALTH IN NIGERIA

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ABSTRACT

There is poor nature of health situation in the world generally and in Sub-Saharan African particularly, these issues became worrisome and mind bugging to world leaders and leading development institutions around the globe. The Millennium Development Goals (MDGs) was a right target to reduced maternal motility within its specific period of time, given 2015 as a target year. This research paper was targeted to find out post-millennium development goal achievement on maternal health in Nigeria, secondary data were retrieved from National Bureau of Statistic (NBS) and other relevant source of data which were subjected in analysis using graphical data presentation. The result shows recorded slow progress in reducing maternal mortality and creating universal access to reproductive health. Performance in the MDG, especially, in universal access to reproductive health, has been sluggish and possesses greater challenge to women health. Although, there is a significant reduction in maternal mortality rate within the period of research and the level of reduction in maternal mortality (about 53%) is still quite below the target of 75% reduction. Measures to improve the Post- Millennium Development Goal on maternal health have been considered.

Keywords: MDGs, Maternal, Mortality and Health

INTRODUCTION

The role of health in economic growth and development can never be overemphasized. The importance of health was also stressed by endogenous growth theory. WHO (2003) defined health as a state of complete physical, mental and social well-being. In this perspective, good health is a major source for social, economic and personal development and an important dimension of quality of life. Health improvements contribute to other development objectives such as increased productivity, high income growth, political stability etc. Health capital also determines the total amount of healthy time available for people (Oyeniran and Onikosi-Alliyu, 2015)

Record has shown that health status of countries in Sub-Saharan Africa is very poor. The reproductive health indices in these countries are deplorable. Maternal mortality rate is estimated at an average of 500 deaths per 100,000 live births in 2010. People living in Sub-

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Saharan Africa have the least access to an improved water source that could supply safe drinking water as only 45% of people in rural areas have access to improved drinking water source (World Bank, 2014). In Western and Central Africa, mortality rates for under-five are among the highest in the world (Enabudoso *et al., 2006).*

The poor nature of health situation in the world generally and in Sub-Saharan African particularly, these issues became worrisome and mind bugging to world leaders and leading development institutions around the globe. So, they converged and developed a blueprint to channel efforts to meet the needs of the worlds poorest. The blueprint was tagged the Millennium Development Goals (MDGs) with an eight-point agenda and specific target. It is a bundle of developmental goals and a target committing about 189 independent states including Nigeria and virtually all of the world's main multilateral organisations to an unprecedented effort to reduce multidimensional poverty through global partnership .The Millennium Declaration was signed in the year 2000 in New York and the year 2015 was fixed as deadline for achieving most MDGs (Kayode et al, 2012). Three out of eight goals is based on health. These development goals on health are reducing child mortality; improve maternal health or maternal mortality and combating HIV/AIDS, malaria and other diseases (United Nation, 2014). It has been observed that, Nigeria, many sub-Saharan African countries will not meet the Millennium Development Goals by 2015 (Okonjo-Iweala, 2012). Faced with this disturbing reality and the fact that it would amount to a monumental development calamity especially in the Third world if MDG agenda is not continued beyond 2015, the UN Secretary General – Ban Ki-Moon, in 2012 created the UN System Task Team on the Post-2015 Global Development Agenda, and appointed a 27 Member High-Level Panel, with Prime Minister David Cameroon of Britain, President Yudoyono of Indonesia and President Sirleaf Johnson of Liberia as co-chairs with a mandate to design a virile and workable post-MDG development strategy that will be universally acceptable, and which will free the world from extreme want, poverty and hunger, diseases, environmental degradation and wars, and at the same time reposition the world on the path of greater economic prosperity, political stability and peace (UN, 2012).

To achieve these health development goals, the Nigerian government has set up several programme and policies. These include Safe Motherhood Initiative (SMI), Primary Health Care Scheme and Guinea-worm Eradication Programme, Better Life for Rural Women (BLP), The Family Support Programme (FSP), The National Health Insurance Scheme(NHIS), The National Action Committee on AIDS (NACA) and its associated programme for the Prevention of Maternal to Child Transmission of HIV (PMTCT) programme, National Strategic Health Development Plan (2010-2015) (Makinde, 2005; Innocent *et al., 2014).*

However, despite these policies and programs, health situation has not improved in Nigeria. The World Health Organisation (WHO) has also identified Nigeria as one of the 46 African countries that have failed to meet the Abuja Declaration 13 years on and one of the 38

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that are off track in meeting the health-related Millennium Development Goals (MDGs)by 2015 (WHO., 2011). Nigeria has made progress in reducing maternal deaths, but the number of women who die in pregnancy or from complications associated with child-birth remains appallingly high. Nigeria is Africa's most populous country and, despite being one of the wealthiest in Africa, continues to experience high rates of maternal deaths. Nigeria has the 10th highest maternal mortality ratio (MMR) in the world, according to UN estimates, with 630 women dying per 100,000 births, a higher proportion than in Afghanistan or Haiti, and only slightly lower than in Liberia or Sudan (WHO et al 1990-2010). An estimated 40,000 Nigerian women die in pregnancy or childbirth each year, and another 1 million to 1.6 million suffer from serious disabilities from pregnancy and birth related causes annually (USAID Report 2012). Over her lifetime, a Nigerian woman's risk of dying from pregnancy or childbirth is 1 in 29, compared to the sub-Saharan average of 1 in 39 and that global average of 1 in 180. While in developed regions of the world, a woman's risk of maternal death is 1 in 3,800 (WHO 2012).

The Millennium Development Goal on improving maternal health calls first for a 75 per cent reduction by 2015 in the maternal mortality rate from 1990 level for Nigeria (using estimates from the Nigeria's 2008 Demographic and Health Survey by the National Population Commission which is slightly lower than UN estimates), a reduction to 250 maternal deaths per 100,000 live births; and second, for 100 per cent of deliveries to be assisted by a skilled birth attendant (NPC Report 2009). Thus, this study, accesses the attainment of the maternal health-related millennium development goals in Nigeria as post MDGs 2015.

MATERIALS AND METHODS

There are several studies relations to maternal health have been undertaken by credible researchers, most especially with MDGs in meeting up the target of 2015. In this work, secondary data retrieved from sources such as: United Nation Development Proggramme (UNDP), National Bureau of Statistic (NBS), Index Mudex report, World Bank report, CIA report, National Demographic and Health Survey (NDHS) with others relevant literatures were utilized. These data were viewed trends and status: Maternal mortality rate (lives birth and death), contraceptive Prevalence rate, adolescent birth rate, birth attended by skilled personals and antenatal care coverage. These data were tabulated and graphically presented using descriptive statistics are collated and analyzed descriptively.

FINDINGS AND DISCUSSIONS

Nigeria has made steady progress in reducing maternal deaths and moving towards the achievement of MDG. From a high of 1000 deaths per 100,000 live births in 1990, maternal mortality fell to 800 deaths per 100,000 live births in 2004, 545 deaths per 100,000 live births in 2008 and 350 deaths per 100,000 live births in 2012. Maternal mortality declined by 20.0% between 1990 and 2004 and by 36.0% between 2004 and 2008. However, Nigeria's current

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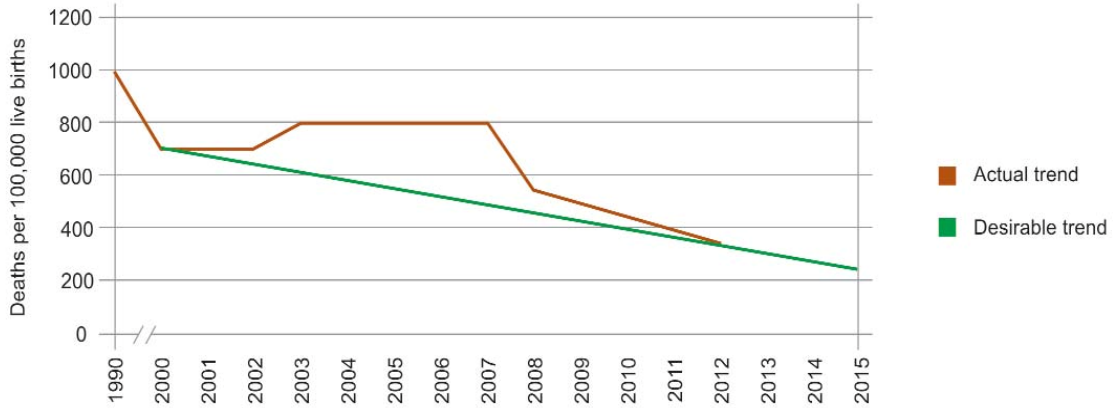
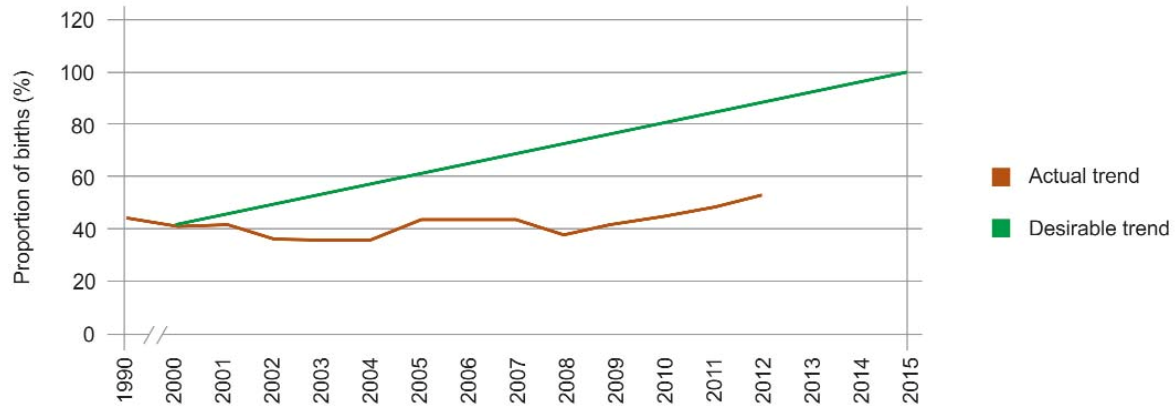
status, estimated at 350 maternal deaths per 100,000 live births, is still 40.0% short of the 2015 target of 250 maternal deaths per 100,000 live births. According to the National Health and Demographic Survey 2008, the major causes of maternal deaths are: haemorrhage, infection, malaria, toxaemia/eclampsia, obstructed labour, anaemia and unsafe abortion (NPC, 2009). The Millennium Development Goal on improving maternal health calls first for a 75 per cent reduction by 2015 in the maternal mortality rate from 1990 level for Nigeria (using estimates from the Nigeria's 2008 Demographic and Health Survey by the National Population Commission which is slightly lower than UN estimates), a reduction to 250 maternal deaths per 100,000 live births; and second, for 100 per cent of deliveries to be assisted by a skilled birth attendant (NPC Report 2009). According to the Nigeria National Planning Commission, the country can reach the maternal mortality target by 2015, but require dramatic and sustained progress in the remaining years (NPC Report 2010).

Figure 1: Trend in the maternal mortality rate (deaths per 100,000 live births) (1990–2012)



Source: NBS, 2013

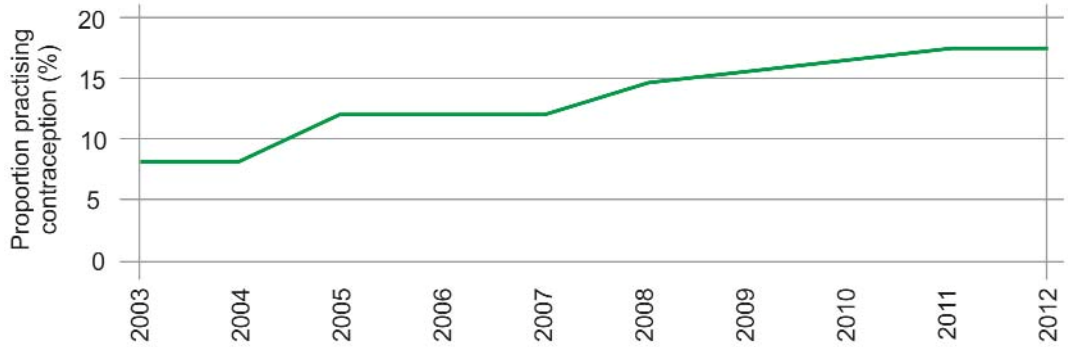
Figure 2: Trend in the proportion of births attended by skilled health personnel (1990–2012)



Source: NBS, 2013

The proportion of births attended by skilled health personnel is the fraction of the total number of deliveries, where trained personnel are in attendance. Such personnel are equipped to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on their own and to care for newborns. There has been a steady increase in the proportion of pregnant women who have a skilled birth attendant in attendance at the time of delivery. It rose from a low of 36.0% in 2004 to 54.0% in 2012. A skilled health professional (doctor, nurse or midwife/auxiliary midwife, community health worker, etc.) can administer interventions, either to prevent or manage life threatening complications during childbirth.

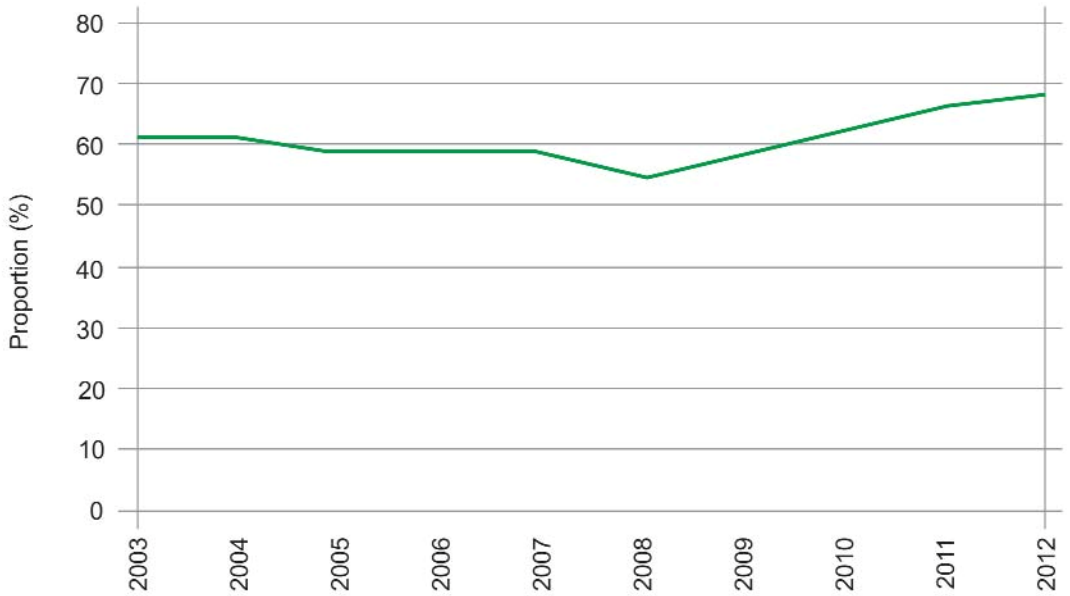
Figure 3: Trend in the contraceptive prevalence rate (2003–2012)



Sources: NBS (2013)

Figure 3. Shows a significant increased access to safe, affordable and effective methods of contraception is providing individuals with a greater choice and opportunities for responsible decision making in reproductive matters. In addition, contraceptive use has contributed to improvements in maternal and infant health by serving to prevent unintended or closely spaced pregnancies. The contraceptive prevalence rate has increased from 8.20% in 2004 to17.30% in 2012. There is still room for improvement given that unmet need for family planning has recorded only a very minimal reduction of 0.80% between 2011

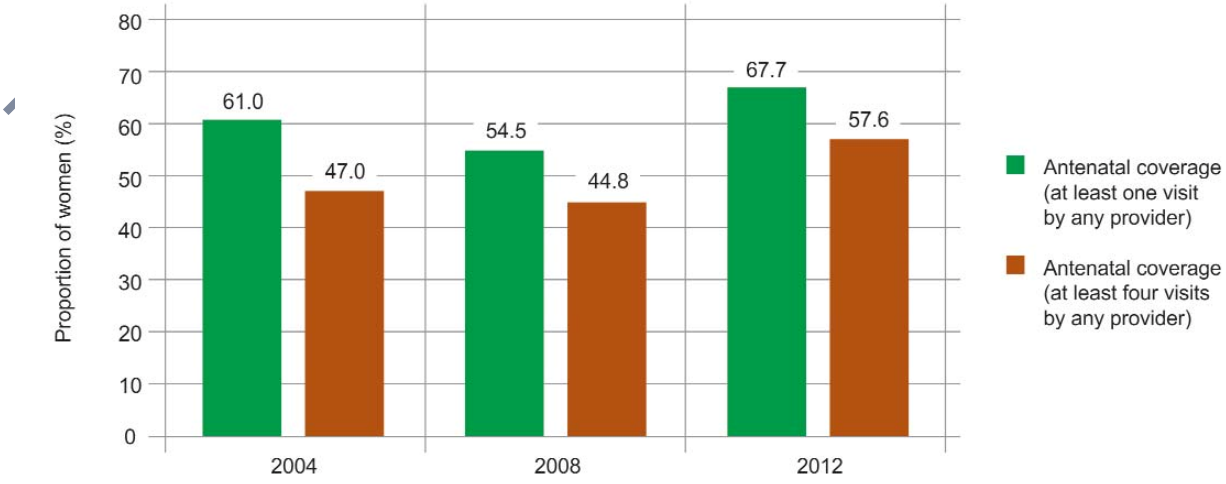
Figure 4: Antenatal care coverage (2003–2012)



Sources: FRN (2010); NBS (2013)

Antenatal care coverage is among the health interventions capable of reducing maternal morbidity. It is critically important and timely too, to reach women with interventions and information which promotes the health, well-being and survival of mothers as well as their babies. Coverage (of at least one visit) with a skilled health worker significantly increased to 67.70% in 2012 from 61.0% in 2004. In a similar vein, antenatal coverage – of at least four visits – rose to 57.80% in 2012 as against 47.0% in 2004 as shown in figure 4.

Figure 5: Antenatal care coverage (at least one visit and at least four visits)



Sources: FRN (2010); NBS (2013)

SUMMARY

Generally, Nigeria recorded slow progress in reducing maternal mortality and creating universal access to reproductive health. Performance in this goal, especially, in universal access to reproductive health, has been sluggish and possesses greater challenge to women health. Although, there is a significant reduction in maternal mortality rate between 1990 and 2013, the level of reduction in maternal mortality (about 53%) is still quite below the target of 75% reduction. As can be seen in figure 1, maternal mortality rate (per 100,000 live births) reduced from the value of 1200 per 100,000 live births in 1990-560 deaths in 2013. Also, the percentage of pregnant women receiving prenatal care has been fluctuating. It increased from 56.5% in 1990 to 61.8% in 2000 and then reduced to 58% in 2005. As at 2013, prenatal care coverage stood at 66.8%. The proportion of birth attended by skill health personnel improves marginally from 30.8% in 1990 to 48.9% in 2012. The poor performance in the mortality rate and access to reproductive health can be attributed to many factors which include; poor medical facilities, incessant strikes by medical practitioners, difficulties in relocation of midwives to the rural areas. The MDG on maternal mortality has drastically improved in such a way that babies were delivered with less structural problems.

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