

Review Article

Avoidable gaps hindering the fast reduction of maternal and infant mortality rate (MDGS 4TH and 5TH) in Nigeria. “Challenges - progressive made and smart solutions”

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Abstract: Increasingly, it is believed that the development of any nation in wealth creation, science and technology hinges so much on the robust nature of the health system available to her citizen. Thus, the health of any community or nation determines to a large extent how productive the workforce would be with sound reasoning ability to sustain life and determinant of health variables. However, one critical huge health challenge in Nigeria and Africa at large is the inability of effectively combating the increasing mortality index of maternal and infant death with its attendance of serious confounding consequences. Nevertheless, lack of coordinated health policies, inadequate funding, decay health infrastructure, huge corruption, ignorance, poor research strategy and lack of dynamic leadership style has been identified as a factor increasing the trend. Thus achieving the Millennium Development Goals of 4th and 5th in Nigeria has continued to pose a tremendous challenge. Sadly, Nigeria has been marked as one of the dangerous place with weak health infrastructure for women to have her baby without complications or death incidence. Nonetheless, the study attempt to critically evaluate, analyse and synthesize the leadership, structure and funding of a comprehensive health care system with the key focus on primary health care. Also the herculean task of achieving the millennium development goals of 4th and 5th was uncovered thus highlighting some of the pitfalls in the system that are hindering the achievement of the goals. It is therefore strongly believed that until Nigerian Government is ready to increase funding for health care, fight corruption, increase research and data gathering technique and mobilize the local populace through community participation. The achievement of Millennium Development Goals would probably not be achieved till 2030. However, more health facilities are needed in rural villages that harbour greater percentages of vulnerable and poor subjects. Furthermore, this should be backed up with prompt political will at all levels of Government in Nigeria, as this would help to scale down the frightening statistics of maternal and infant mortality statistics in Nigeria.

Keywords: Maternal, infant, Mortality, MDGs goal 4th and 5th, Nigeria, Poor funding, Gaps, Research, Governance and Smart Solutions

INTRODUCTION AND BACKGROUND INFORMATION

According to the Nigeria National Population Commission report [1], Nigeria is the most populous Black Country in the world and remains strategic in Africa and the world in general. It has been reported that Nigeria is one of largest producer of oil in Africa and ranked 12th of the producer of oil and gas in the world [2].

Furthermore, given the large amount of oil deposited in Nigeria soil, it is sad to note that Nigeria still ranks 156th out of 187th among nations with a high rate of poverty [3]. This may probably be linked to corruption and poor planning in the management of

resources. However, given the above poor developmental status of Nigeria, it, therefore, translates that Nigeria will be faced with a myriad of health inequalities including a high index of maternal and infant mortality, malaria, poverty and HIV/AIDS that are preventable [4].

The government of Nigeria is known and addressed as Federal Government of Nigeria and operate a federal system of government with 36 states and federal capital territory in Abuja [5]. The states are further grouped into six geo-political zones namely North-East, North-West, North-Central, South-South, South-West, and South-East. It was projected that by 2020, the population of Nigeria will hit 200 million

though currently the population of Nigeria is about 150 million [6]. However, about 60% of Nigerian population are residing in the rural communities though urban migration is speedily increasing with time for better livelihood [7]. Furthermore, it was also reported by UNDP (2010[8]) that 45% of Nigerian population are under the age of 15 years with the rapid population growth of 2.83% that is increasing higher than the global average of 1.17 % respectively.

Economically, Nigerian primary sources of revenue are through the oil and gas with about 90% of the country budget revenue, about 99% of the export income and about 53% of the gross domestic product respectively (GDP) [9]. Interestingly, health is wealth, and one of the greatest world health challenges is the increasing trend of infant and maternal mortality rate, especially in Africa that bears the enormous percentage of the burden which Nigeria is not left out ([10; 11]. The consequences of maternal death on national and global development are worrisome and calls for urgent and more integrated attention to address. It's impacts transverse nations, communities, individuals and thus has remained a massive barrier to sustainable socio-economic development and emancipation of any society [12]. Furthermore, maternal mortality takes away family and community joy; man-hours are reduced and children education are hampered [13]. It was based on the grievous impact of maternal mortality that it was raised as a major issue in September, 2000 United Nations Submit in New York which was tagged Millennium Development Goal Submits that has eight significant issues to address by 2015. One of the prime targets is to reduce by two-third infant mortality and three-quarters maternal mortality prevalence across the globe by the end of 2015 [14, 15].

However, a report from the World Health Organisation [16] revealed that Nigeria is one of the most hit countries in the world with the challenges of maternal health and has remained one of the countries that parade the highest statistics in the prevalence of child and maternal mortality in the world. Nigeria is therefore described as the most dangerous and ill-equipped place in the world for women to have a birth despite all the efforts put in place by regional and relevant global health agencies to reduce the trend [17]. It was estimated that 630 of every 100,000 live births ends up with maternal death in Nigeria [18]. Furthermore, Nigeria accounts for 14 percent of maternal mortality across the globe, and the country has maintained one of the ten most dangerous places across the globe for a woman to give birth [19].

However, the causes of maternal mortality are multifaceted, hence according to WHO factsheet [20] about 8 percent of maternal death globally are caused by four major risk factors namely, hypertensive disorder

in pregnancy, obstructed labour, infections and severe bleeding. Also, 13 percent of maternal deaths are caused by complications from unsafe abortion. Furthermore, other indirect causes of maternal death are anaemia, meningitis, HIV/AIDS, Sickle cell anaemia, acute renal failure and lack of adequate care [21]. In Nigeria in particular, 70 percent of maternal death could be linked to unsafe abortion, haemorrhage, infection and pregnancy-induced hypertension as reported by [22]. Nevertheless, poor access to maternal clinic also contributes immensely to the increase in maternal death in Nigeria. Besides, other risk factors in Nigeria that also promote high mortality rate include non-utilization of facility and ignorance as opined by [23].

According to the Nigeria National Health Conference Communique held in 2009, Nigeria is one of the countries in the world with the highest increasing statistics of maternal and infant mortality [24]. The reports also stated that shortage of resources such as drugs, inadequate and decaying infrastructure, inequality in resource distribution and deplorable quality of care are some of the critical issues. Also, lack of co-ordination and strategic planning are some of the key factors that has promoted the weakness of tackling the high rising statistics of maternal and infant mortality in Nigeria [25]. However, certain measures although not enough has been put in place by various agencies of federal and state governments in Nigeria to bring down the increasing trend as reported by the National Demographic and Health Survey [26]. The report shows that the South-West part of Nigeria has the highest maternal mortality burden. Thus, these have informed the governor of Ondo State to initiate an intervention programme called 'Save Motherhood Programme' in 2009 with the sole mandate of reducing the mother/infant mortality rate in the state in line with the millennium development goals [27]. Having given a brief background of maternal health challenges in Nigeria. It will be imperative to state very clearly that this piece of study would attempt to uncover some of the factors promoting the trend, progress made so far and proffer some recommendations in the end, although not all the articles that bordered on this subject area were reviewed. However, the aim is to continue to bring to the front burner some of the health challenges facing Nigeria with the view of providing solutions and health educating the general public. The next heading will look at the epidemiology of maternal mortality in Nigeria.

EPIDEMIOLOGY OF NIGERIA MATERNAL MORTALITY AMONG WOMEN OF CHILDBEARING AGE (15-49)

Maternal health remains one core area of interest for global development. Hence, these could be defined as a total and comprehensive care surrounding child-bearing, this include postnatal care, antenatal care and delivery assistance according to Department of

Health and Statistics [28]. It further encompasses the medical approach towards prenatal, preconception, family planning and post-natal care that is deliberately targeted towards reducing maternal morbidity and mortality in the end [29]. However, maternal mortality rate could be defined as the number of women who die per 100, 1000 live deliveries on pregnancy-related complications that are preventable [30]. The explicit explanation of maternal death entails the death of a pregnant woman or pregnant-related issues within 48 days of termination of pregnancy. The infant mortality rate is the death of a child before the first birthday, and it is measured in the number of death per 1000 infants [31]. It is believed that one critical challenge militating against the holistic development of a robust maternal health strategy globally is the increasing statistics of maternal and infant mortality rate without strategic planning of control [32]. Every year globally, it was reported that about 287, 000 women die in childbirth due to pregnancy-related diseases. Over, 7.6 million children believed to be less than five die mostly from treatable and preventable illness [33]. Statistics also show that more than 25,000 infants die every day and every minute, a pregnant mother dies in childbirth [34]. Nonetheless, evidence suggests that African accounts for the highest prevalence of mortality among women and infants across the globe [35]. Regrettably, in spite of all the efforts by the states and national government, Nigeria still account for about 14 percent of maternal mortality in the world. She has been tagged as the most dangerous place to give birth [36].

According to World Health Organisation that disclosed that 630 of 100,000 lives birth results and ends up in maternal mortality [37]. It further estimated that maternal death in Nigeria happens per hour, 90 per day and 2,500 per month and for a total of about 34,000 death per year [38]. In continuation, [39] also reported that the death of a pregnant mother in Nigeria happens in every minute. Thus such death threatened and shattered the hope, peace and wellbeing of the immediate families and relatives, it could be posited that the welfare and health of women are very critical as they are seen as an agent of socio-economic development of any society. For example, it was further reported by [40] that for the death of any single woman, it will have about 20 or more ripple effects of series of complication in the family.

However,[41] argued that maternal mortality cases should be seen and addressed as human issues rather than woman problems, although some factors that are linked to maternal mortality according to [42] are weak health system, cultural barriers to utilizing health facilities and inadequate socio-economic development. Also, lack of skilled birth attendant, poverty, shortage of health professionals and high illiteracy rate that promote the desire of the women to patronize and visit

traditional birth attendants who are not trained professionals for child delivery. Thus, these have increasingly worsened the safe delivery outcome in Nigeria [43].

Furthermore, there are indirect and direct triggers of maternal and child mortality rate in Nigeria. Hence inappropriate feeding habit, poor hygiene, inadequate funding, inappropriate cultural barriers, food insecurity and malnutrition are all under the direct causes of maternal and infant mortality. The indirect triggering factors that play a huge role to a large extent in increasing the maternal health statistics include lack of access to health care and lack of primary education that are most times linked to early pregnancies. These factors above are associated with the increasing trends of prevalence of maternal mortality in Nigeria [44;45] also reported that poverty due to political and geographical marginalisation, social discrimination and exclusion are also significant factors that have promoted maternal mortality in Nigeria [46]. The monitoring and evaluation of maternal mortality rate cases in Nigeria are always very cumbersome due to non-dependable statistics. It is also always associated with poor reporting and lack of sound methods to measure the actual mortality rate and data storage [47].

It was reported that only 31 percent of the women register and deliver their babies in health centres in Nigeria, due to poverty and lack of awareness of the gains accruable in such practice [48]. Given the increasing trend of huge statistics of maternal and child mortality in Nigeria. The author believed that it is becoming very evidence that Nigeria may not probably achieve the millennium development goals that anchors on strengthening maternal and child health due to poor health negative indicators. The next heading will be Nigeria health system, funding and governance.

NIGERIA HEALTH STRUCTURE; GOVERNANCE AND FUNDING

The elements that will be presented below will explain the structure of Nigerian health system, management/governance structures and how the system is funded to achieve its goals.

According to the report from the federal ministry of health [49], Nigeria operates a heterogeneous, complex and broad-based health care system. These are encompassing of traditional health care providers, faith-based organisation (FBO), community-based organisation (CBO), the public and private sector that is of profit making oriented (World [50,51]). Thus given the above composition, the health sector could be conveniently being divided into public and private health sector. It is critical to state very clearly that the private health sector accounts for 38 percent of all the registered health facilities in Nigeria.

The secondary care level account for 22 whiles the primary health care account for 75 percent [52].

Furthermore, public health in Nigeria revolves around the three tiers of government structure, namely the federal, state and the local government level [53]. The federal government controls the tertiary institutions that serve as referral points for patients from the state and local government level. They control the teaching hospitals, federal medical centres and national hospitals that serve as a training centre for the staff of the states and local level health centres. They are also responsible for dissemination of information, formulations of health policies, co-ordinate and supervise other levels of government [54, 55].

The state government provides health care services at the secondary level through the state-owned general hospitals, specialist hospitals and comprehensive health centres. They serve as the point of entry for referral services for the patients at the local government level. General medical services such as minor surgery control of medical laboratories services and drug stores within the state are controlled by the state government [56; 57]. The state- owned hospital takes care of obstetrics and paediatrics services also. Lastly, the local government that is the third tier of government handle the management of primary health care. They are the entry point for health care services among the grassroots citizens who are living in the rural villages. They are majorly involved in disease prevention strategy such as immunisation, sanitation, health education and family planning services. Examples are the health centres, drug dispensary post and cottage health centres [58].

NIGERIA HEALTHCARE LEADERSHIP/REGULATION:

In Nigeria the federal ministry of health (FMOH) approves the schedules of guidelines and responsibilities that are disseminated across the three tiers of government as mentioned earlier. The Constitution of Nigeria places all the health issues on the concurrent legislative list, thus creating a complex and overlapping functions of the federal, state, and local government with respect to designs of policies and provision of regulations [59, 60]. However, it is believed that the Constitution was silent and thus fails to provide specific responsibilities and functions of each tier of government, leading to complication and confusions in the management and administration of health at all tiers of government [61; 62].

Thus, this has created the lack of check and balance in the health system. Also, critics have also frowned at the lack of autonomy of the local government council for the management of primary health care as a setback, even when the local

government has the primary responsibility of providing quality healthcare at the grassroots [63]. Nonetheless, it is believed to be solely controlled by the federal and state government primary health care board and her agencies which have instituted much confusion in the system [64, 65]. However, World Bank [66] opined that lack of autonomy may probably be linked to massive financial dependence on the state and federal allocation of funds monthly from the federated account, which could probably be as a result of low level of internally generated revenue at the local tier of government [67].

In continuation, the impact of lack of autonomy is also felt at the level of lack of control among the 75 percent of privately owned health facilities that mostly deliver care at the primary care level. Nevertheless, license for operation is issued by the State Ministry of Health (SMOH) to ensure that the private health providers operate within the confines of the law and regulations. More often there are obvious cases of non-enforcement, evaluation and monitoring to guarantee the excellent standard specified according to Demographic and Health Survey Report (DHSR) [68]. Thus, majority of private health care providers remains unregulated and unchecked at the local level due to lack of constitutional powers. In the same vein, it was reported by NHDS, [69] that 60 percent of Nigeria population lives in the rural communities, hence the weakness and lack of control of the health care providers at the local level could probably put the majority of the population at risk.

It was also evident that rural communities lack specialized equipped hospitals, therefore, depends solely on private providers for health care needs. For example in a study carried by Ministry of Health Kano State in 2006 which revealed that one patent medical vendor caters for 3,000 subjects that run contrary to WHO standard that states that one primary health centre to cater for every 1,500 subjects [70].

NIGERIA HEALTHCARE FUNDING:

It is believed that adequate funding of a healthcare system of a country remains very critical if the country must attain enormous success towards sustainable development and efficient healthcare delivery of her citizens [71; 72; 73]. Funding of health is achieved through a combination of donations from donor agencies, out of pocket spending, tax revenue and national health insurance scheme (private and public) [74]. Nigerian health expenditure was reported to be low when compared to other African nations. Between 1998 -2000, the percentage of gross domestic product (GDP) of Nigeria health expenditure was less than 5 percent, falling behind THE/GDP ratio when compared to the other developing nations like South Africa (7.5%), Malawi (7.2%), Tanzania (6.8 %), Zambia (6.2%) and Kenya (5.3%) [75]. Nevertheless, having

mentioned the various ways health system is being financed in Nigeria, the author would explain in brief the impact of each method in health care delivery.

The funding of the Tertiary, Secondary and primary health care in Nigeria comes majorly from the federated account allocation [76]. This is fund generated from taxed based system from the services and sale of oil and gas [77]. The percentage government expenditure in health was projected to be 18.69% in 2003, 26.40% in 2004 and 20.02% in 2005 in Nigeria, but this was unrealistic probably due to poor planning and budgeting strategy [78]. In Nigeria, the use of population size of each state and quota system is used as an index for the allocation of the fund. These most time disadvantage some states with small population size but with tremendous health challenges hence such states has limited fund allocation to tackle health issues. For example, the South- South region of Nigeria has the lowest in population size but the highest rate of infant mortality of 120/1000 lives birth thus receives small allocation (fund) in the health sector [79].

The World Bank also suggested that the poor funding allocation to health could be as a result of only 3.5% proportion of GDP that is allocated to health sector as against 15 % of WHO recommendation [80]. The condition is worsened by the massive corruption level and poor managerial indices visible at all levels of healthcare delivery system [81], more especially in the public health system that has promoted the lack of accountability of the limited scarce resources. It is sad and pertinent to reiterate that in the midst of current economic hardship and high level of poverty among families approximately 80 percent of revenue in health are generated by out of pocket payments for health services by families. Hence, this forms the largest source of revenue of funding health sector in Nigeria; the services include entrance fees, drug, medical test fees and consultation fees [82]. It was reported that out of pocket expenditure from 1998 -2002 averaged 64.59% as a proportion of total health expenditure (THE) [83]. Also in 2003 it accounted for 74%. However, it decrease to 66% in 2004 and finally increased to 68% in 2005 [84].

It will be stated further that user fees were introduced in 1998 under the Bamako Initiative that was aimed at strengthening the funding of health sector through community involvement [85]. These could be augured and supported to be right as the majority of the citizens that resides in the villages patronize private health care providers who are only out for high-profit making than rendering qualitative health care service [86]. Furthermore another source of health funding is through the provision of National Health Insurance Scheme (NHIS) which is a contribution that is regulated under tight supervision by an insurance firm appointed

by the government [87]. Most times only federal government staff and her agencies are covered as the majority of those who are not covered by the scheme who seek for medical attention in different states, pay their bills by themselves [88]. The scheme comes under the ACT 33 of 1999 constitution with the aim of reducing the financial burden for easy access to healthcare delivery. Thus it comes into operation in 2005 [89]. The author believed that this trend may also help to create a wide gap of inequalities in health care services in Nigeria thus calls for urgent attention through well planned and accessible intervention.

It was reported that only the formal sector in Nigeria which includes, Police, Army and other uniform services men that made it mandatory for their members has achieved 90% coverage, although presently it is expounding to Cross River and Bauchi State which has achieved full coverage [90]. Nevertheless, World Bank survey [91] reported that only 0.8% of Nigerians are covered by National Health Insurance Scheme, which indicates that much is needed to be done in providing affording health care delivery services in the country especially among the antenatal women who are vulnerable to myriad of infections and health risk.

Furthermore, another source of funding of Nigeria health system is through the financial assistance and donations from international donor agencies such as WHO, UNICEF, USAIDS and Global Fund to support socioeconomic, health development infrastructure and strategic planning in Nigeria. However, financial assistance by the donor agencies has witnessed many setbacks and has not been impressive until the return of democracy in Nigeria in 1999 [92]. In view of the above, it was reported that the average annual official donation assistance to Nigeria between 1999 to 2007 was projected at US\$2.335 and US\$4,674 inflow per capital [93]. It is strongly believed that these figures are far below the Sub - Sahara African average of US\$28 per capita respectively [94, 95].

Besides the support of financial donations to health care delivery in Nigeria was estimated at N27.87 billion (4% of THE) in 2005 [96]. However, there is increasing improvement of international assistance to Nigeria health sector but these nevertheless still account for the small proportion of total money of public expenditure spent by Nigerian government, thus more support is needed to reduce the gap of inequality in health [97]. The effective coordination of funds, strategic management and tracking donor resources inflow remains a major challenge and drawback to Nigeria donor funding outcome [98]. Also, lack of streamlined coordination from the federal government to state and local government council has also created lack of unity of purpose towards pursuing a joint health targets or goal as each state has a different health

priority different from the priority at the centre [99]. Furthermore, other challenges that have affected the financial aids to Nigeria health system are the problem of providing the counterpart funding when needed, institutional weakness, uneven spread of donor activities, high cost of technical support and lack of donor-driven approach to aid service delivery [100].

Arguably, the impact of aids effectiveness and its gains in the micro-economics has been debated by several scholars with huge concern [101, 102]. Notwithstanding, some opinions still believed that aids from donor agencies still maintain an important aspect of health care assistance to developing countries including Nigeria, that is targeted towards strengthening the health care system and providing quality care especially in the rural communities where access to health care has remained a challenge. However, as stated earlier that funding from donor agencies has not been promising and efficient of recent, probably due to lack of accountability and clear-cut strategic planning on the part of Nigeria government. The author would move further to discuss some of the initiatives taken by Nigerian government to reduce the burden of high rate of maternal mortality in Nigeria and possibly discuss some of the setbacks towards achieving a remarkable achievements.

NIGERIA GOVERNMENT'S EFFORTS TOWARDS REDUCING MATERNAL MORTALITY

Several attempts have been made in the past by successive governments of both federal and state toward reducing the increasing rates of maternal death, but such measures have not yielded many significant gains. However, these are some of the policies and declaration adopted. The safe motherhood initiative that was launched in Kenya in 1987 by the United Nations that was aimed at reducing the estimated yearly world maternity mortality figure of 500,000 by 50 percent by the year 2000. It was also launched in Nigeria in 1990. Also, Nigeria was also involved in Beijing conference held in 1995 which also aimed at reducing maternal mortality rate [103]. Others are the fourth conference on women in 1955, the world summit for children (WSC) in 1990 [104]. And United Nations Millennium submit 2000 that come up with the Millennium Development Goals with the target of reducing maternal mortality by third quarter (75%) between 1990 -2015[105]. Furthermore, other regional treaties, declaration and policies include 1988 National Policies on Health [106], Reproductive Health Policies and Strategy [107] and Integrated Maternal, New-Born and Child Health Strategy in 2007, National Millennium Development Goals Reports [108]. Also, Nigeria was involved the famous ALMA ATA declaration of 1978 [109].

Nevertheless, of recent some promising results has begun to be appreciated due to probably some effective policies and initiatives taken by some state governors in Nigeria to reduce the burden, although not there yet. It was reported by [110] that the state House of Assembly of Anambra State in 2005 approved free medical care for pregnant mothers in the state, as these was very helpful. Also in Kano State, government included a separate budget for free maternal health care services and the construction of new obstetrician and gynaecological clinic to enhance safe delivery in the state. Similarly, in Jigawa state, the state government collaborated with the local government council to provide fund for the provision of an ambulance to transport women who are in labour to nearby health centres, upgrade the obstetric care centres, engage more qualified health workers with incentives. This boosted the maternal health care in the state [111].

According to Sunday Punch, [112] the setup of five well-equipped health centres with qualified staff in different locations in Lagos State that was providing free medical services to pregnant women has tremendously improved the quality of maternal health in the state. These are currently ongoing efforts in different states towards reducing the high rate of maternal mortality cases in Nigeria. Besides another one called Abiye initiative that was set up by Ondo state government targeting the pregnant mothers in the rural villages was very critical. It was reported by World Bank [113] that 51.6 percent of Nigerians lives in the rural communities thus this high vulnerable group in the villages were able to access health care through this initiative. They were provided with a toll-free handset prepaid by the government and are tracked by trained staff to monitor the state of their health from time to time [114]. Thus because the calls are free, the difficulties in accessing health care was removed as some medical staff was positioned to visit them with motorcycle from time to time with a first aid box and can only move them to health centres if the situation is complicated [115]. It was reported that the gap in accessing health in those villages was reduced to zero level even as maternal health registration in the state increased tremendously [116].

Nonetheless, given to all the right initiatives by the various state governments, some key elements that was common to them all as noted are uncoordinated approach, corruption and inconsistencies. Also, lack of mission by various successive state governments to sustain the drive of the initiative after the expiration of the tenure of the government of the founder of the initiative [117]. Besides apart from the efforts made by the various state governments to key into the primary target of Millennium development goal of 2015 that are aimed at improving maternal and infant health care especially in high-risk endemic regions. The Nigerian

federal government at the centre has also put in place several interventions towards this direction. Already the following initiatives are ongoing: The initiative of capacity building of training and retraining of nurse and midwives in current trends in maternal and child care services. This is one great scheme that would empower the health workers to save more lives, even as they are exposed to reproductive health and significant of immunization to prevent killer diseases among babies.

Again the strong advocacy initiated by the Nigerian First Lady (president wife) to raise awareness campaign on maternal and health child health, safe delivery among stakeholders in the villages and towns in Nigeria was very helpful in creating awareness on safe and hospital delivery. Also the launch of an initiative called African Union Continental Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and the Journalist Alliance for prevention of Mother to Child Transmission of HIV/AIDS was a very brilliant steps in the right direction to reduce the burden in the region [118].

Besides, the role of international health agencies has been remarkable. Hence, WHO in collaboration with USAIDS, World Bank and United Nation (UN) has continued to improve maternal health through the provision of financial, technical, leadership support. They also provide safety and policy guideline for safe delivery initiatives, even as they provide evidence-based global integrated best practice in research and retraining of health personals in the management of maternal mortality cases [119].

CONCLUSION

Conclusively, despite, massive, impressive initiatives by federal and state governments towards improving reproductive health and increase access to the maternal facility in Nigeria. It is strongly believed that the programmes are not well articulated to achieve the desired goal of the Millennium Development Goals with respect to maternal health which has remained unrealistic and unachievable. Nigeria still remain one of the countries with the alarming statistics of maternal and child death in the world [120]. Evidence-based report suggests that with the level of progress made in health policies which is slow, coupled with corruption menace in health sector. Nigeria may not likely achieve this goal before 2040 and not even 2015 mandate which is a great challenge and a great disaster towards improving maternal health and saving lives of the women [121].

It therefore, implies that achieving the target goals set up by United Nation (UN) (Millennium Development Goals) and the Alma-Ata Declaration on primary health- care by all member states of the WHO in 1978 [122] on child and maternal health cannot be

attained through uncoordinated efforts but must be backed up with actions with greater political will. The entire process seems complicated and slow in nature. Therefore, these suggest that many women would die during pregnancy and after pregnancy due to a preventable disease that could be eliminated through robust commitment and focused healthcare regulations and interventions [123]. Non-allocation of adequate funding in health has been identified as a factor, in 2008 the Centre for Reproductive Health disclosed that Nigeria spent 5 percent in health which is one-third of what was agreed to be budgeted in health on a regional treaty that year. This contravened the regional agreement to make health care accessible especially among antenatal and infant population [124]. This has continued to place Nigeria on the back bench when it comes to efficient health care delivery system among the committee of nations in the world.

SMART RECOMMENDATION

Given the above circumstances, the following are some of the identified problems and some of the smart solutions proffered to improve the maternal health and also help towards the achievement of the millennium development goal of 4th and 5th.

1. Lack of leadership is a very critical element that may truncate the health care system of a nation. The leaders in health care must be visionary, proactive and be ready to back it up with action, creating enabling environment for people to make inputs and collectively developing a mechanism for achieving positive change. The system must be open to accept positive suggestions and run an all-inclusive leadership style with a transparent two ways communication strategic approach.
2. Lack of accountability is another problem in health care system of Nigeria, which has provided room for corruption. Policies should be organised in more transparent manner that would give the citizens the room to articulate their views and exercise their legal right in more open way through regulations and advocacies.
3. Poor health sector funding of 3.5% GDP in Nigeria should be increased to 15 % as agreed in WHO MDG'S meeting, hence the need to improve funding and also protect the funds that are budgeted for health care delivery would help to scale up the gains and achievements in health care delivery.
4. Lack of well-equipped health facility is another huge setback hence more equipped healthcare facility should be provided especially in the remote villages for easy access.
5. NHS should be extended to everybody especially pregnant women in the villages with

frequent need of health education to underpin the gains.

6. Lack of enforcement and regulation of private sector by the state should be reviewed with the view of proper supervision and enhanced control. The effective control and regulation of the practice of private health providers would help to improve the quality of health care.
7. The disbursement of funds to states should not be based on population size rather on the level of disease burden to provide adequate fund to states that has massive health issues
8. There should be clear cut statement by the federal government to show clearly the duties of the state and local council. The local council should be granted autonomy for ultimate improvement in primary health care and accountability of scarce resources should be stressed.
9. The importance of research and improved data collection strategy cannot be overemphasised. This would certainly help to scale up improvement and will also help in good planning and allocation of fund for effective use.

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