THE IMPACT OF HEALTH POLICY ON MATERNAL AND CHILD MORTALITY RATE IN NIGERIA: A STUDY OF SOME RURAL COMMUNITIES IN RIVERS STATE OF NIGERIA

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ABSTRACT
This paper assesses the impact of Health policy on Maternal and Child mortality rate in some rural communities in Rivers State of Nigeria. Its main aim is to establish how the implementation of the health policies has achieved its set goals. Primary and Secondary sources of data collection were utilised. Some members of the selected Communities were interviewed and relevant documents reviewed. Findings revealed that despite the availability of international and national intervention/ policies for delivering quality Maternal and Child Health Services, significant cause of failure in the policy remained the yawning gap between plan and realisation. Well intended policy programmes remain unimplemented. Corruption, Loose budgetary arrangements, poor coordination between the three tiers of government, inadequate monitoring of programmes and incompetence on the part of health givers are some other challenges. Also revealed is that many people are not making use of available health services due to high cost in assessing medical facilities; the bulk of health funding is borne by households, who made out-of-pocket payments for health care services. This meant that whether one is rich or poor, the amount one pays for health care is the same, which makes health care in Nigeria highly inequitable. These have serious implications for maternal and infant/ child health. The paper concludes that Nigeria's maternal and Child Health system remains weak and the policy has not been successfully implemented and monitored. It was recommended that enhanced funding, proper monitoring and periodic evaluation of programmes should be emphasised. Also, a vigorous policy of educating expectant mothers, adolescent girls and other women of child bearing age on basic hygiene and proper nutrition is recommended.
Key Words: Government, Public Policy, Maternal/Child Health Care, Mortality and Morbidity

INTRODUCTION
Good health is central and indispensable to human existence and wellbeing (WHO: 2005). Therefore a healthy population is a sine qua non for development and productivity. In the same way the health and well being of a mother is inextricably

linked to her unborn baby. In Nigeria just as elsewhere in the world, it is increasingly acknowledged that conditions during pregnancy and delivering are major determinants in the survival of a mother and child. Maternal and Child Health (MCH) care include various services relating to maternity and basic Childhood health care. Maternal Health care covers all activities ranging from ante-natal, delivery, post-natal, and maternal care around child delivery given to a woman of reproductive age. On the other hand Child Health Care includes all medical assistance such as childhood vaccination coverage, child illness treatment as well as prevention of childhood mortality of babies between the ages of Zero and five (MCHS, (2002), FMOH:(2002), Demographic and Health Survey: (2003).

Maternal and Child Health is a cause for great concern in Nigeria as in other developing countries due to the high rate of morbidity and mortality of mothers /newborns. There is no gainsaying that a mother's death during childbirth is excruciating both in terms of the pains of physical loss and the consequences it portends for the other children, family members and the society at large. UNICEF (2007) revealed that an annual estimate of 52,000.00 Nigerian Women die from pregnancy related complications. A study of the Federal Ministry of Health (2007) also has shown that a woman's chance of dying from pregnancy and childbirth in Nigeria is 1 out of 13. Many of these deaths are preventable yet the coverage and quality of health care services in Nigeria continues to fail women and children. Health review (2006) noted that the health condition in Nigeria is dismal and effort to change the situation over the years has been insignificant. This was supported by the submission of the Revised National Policy Document (RNPD: 2004) that the overall health performance of Nigeria was ranked 187th among 191 member states by WHO in 2000. The same report stated that "a very high proportion of primary health care facilities are in a prostrate condition, diagnostic and investigative equipment in tertiary health institution are outdated while the referral system between various types of health facilities is either non functional or ineffective" (RNPD: 2004:2). The effectiveness of a country's health care delivery system is central to meeting its health Goals. Despite the availability of various policies and intervention programmes for ensuring the delivery of quality maternal and child health service, Nigeria is left with an alarming statistics of maternal and child morbidity and mortality rate. UNICEF (2007), study revealed that the integrated Maternal, Newborn and Child Health Strategy (IMNCH) to revitalize primary health care were seriously undermined by the nearly two decades of Military rule. Between 1985 and 1993, per capita investment in health had stagnated at about $11.00 per person compared to the international recommendation level of $34 per person (WHO: 2000). Nigeria health care system performed abysmally low when compared with other less endowed African Countries. For example, in 2005, Uganda allocated 11% of her total budget to health care, while Nigeria in 2006, budgeted just 5.6%. Despite its high percentage of HIV prevalence,

Uganda was ranked 14 out of 191 countries and came 39 steps ahead of Nigeria at 187/191 in the World Health Report of 2000 (WHO:2000). Nigeria's low level of expenditure on health care per capita seemed to be a major challenge in the quest to achieve MDG"s 4 and 5 by the year 2015. This paper is focused on the impact of health policy on Maternal and Child Mortality rate in Nigeria with particular reference to rural communities in Rivers State of Nigeria.

Maternal and Child care in Nigeria has suffered from great neglect. Primary Health Care centres are dilapidated with either expired drugs or non availability of it. Quality skilled care for women during pregnancy and after child birth, comprehensive family planning, Integrated Care for HIV/AIDS, Malaria and others are not at their best performance in Nigeria. Maternal /child death thus continues unabated in Nigeria. WHO (2015) and UNICEF (2015) in their separate report, stated that Nigeria is the next Country after India with the highest maternal mortality rate in the World which is estimated at 814 deaths/100,000 lives births. Reproductive health experts and advocacy group have also reported that Nigeria's maternal mortality is still at 567 deaths per 1,000 pregnant women. UNICEF (2006) and UNICEF (2012) reiterated that every single day, Nigeria losses about 145 women of childbearing age which makes the country the second largest contributor to the maternal mortality rate in the world, signifying unfortunate heartbreak to several families who have lost their love ones to child bearing.

Similarly statistics has it that globally each year about 3.3 million babies are stillborn. More than 4million die within 28 days of coming into the world, and a further 6.6 million young children die before their fifth birthday. This situation is prevalent in Nigeria where infant/ Child survival rate is still very low. Human Development Report (HDR: 1998) and WHO (2011) revealedthat Infant and under-five mortality rates in Nigeria were as high as 114 and 191 per 1,000 live births respectively. It declined to133 in 1999 and rose again to 201 in 2004. WHO (2004) in a study of maternal and child mortality rate, found that about one million Nigerian Children die each year before their fifth birthday. UNICEF: 2006 and 2012), further revealed that every single day, Nigeria losses about 2,300 under five year old children to death. This figure represents about 10% of the global total, even though Nigerian population is just 2% of the world's population. This was corroborated by the study of okolocha et al (1998) and Kayode et al (2012) respectively. This in Nwaokocha (2007), view gives rise invariably to the highest number of high-risk pregnancy and childbirth in the region. This also shows the close relationship between the wellbeing of the mother and the child, and justifies the need to integrate maternal newborn and child health interventions in Nigeria. In view of the above, it is pertinent to ask the following questions to direct the course of this study; what are the causes of maternal/child

mortality in Nigeria? Are they challenges in implementing maternal/child health care Policy in Nigeria? If yes what could be done to alleviate these challenges?

From the above questions the primary objective of the study is to evaluate the impacts of the Health Policy on Maternal and child health care delivery in Nigeria. The paper will also establish the causes of maternal and child mortality in Nigeria, highlight major challenges facing successful implementation of Maternal and Child Health policies in Nigeria and, recommend policy options and suggestions on how to strengthen Maternal and Childs Health care Policies in Nigeria. This paper is therefore focused on the impact of health policy on Maternal and Child Mortality rate in Nigeria with particular reference to rural communities in Rivers State of Nigeria.

Theoretical Exposition

World Health Organisation (WHO:1988) sees maternal morbidity as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and size of the pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.In the same vein, the American Journal of Public Health (2012) defines maternal morbidity as a condition that adversely affects a woman's physical health during childbirth beyond what would be expected in normal delivery. On the other hand, Child mortality also known as under-five- mortality refers to death of infants and children under the age of five.

Caplan et al (1982) sees health as a state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized. Health has also been conceptualized as a state of complete physical mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organisation: 1946). Sofoluwa (1996:120) collaborates this in his view that health is the ability of an adult to remain healthy through qualitative, affordable housing, availability and affordability of nutritious food, generous supply of health facilities to ensure early diagnosis and to effect early treatment or start rehabilitation measures when necessary. From the various definitions of health put forward, it can be deduced that health connotes the sum total of an individual's well-being, guaranteed enough to enable an individual to live a wholesome life.

The environmental condition under which an individual lives is a determinant to the individual's health status, hence it is argued that health is maintained and improved upon through the efforts and intelligent lifestyle choices made by an individual and the society.

The Causes of Maternal and Infant/ Child Death

In a systematic review of studies of maternal mortality WHO (2008) attributes causes of maternal mortality to severe bleeding, hypertensive diseases and infections as the determinant causes. Okiebunor, et al (2010), in a study in Enugu state of Nigeria reported Maternal Mortality Rate (MMR) of about 1,400/100,000 live-births in the state. They attributed the MMR to preventable medical causes, socio-cultural factors, and poor access to skilled medical personnel. Delivering care services to pregnant mothers and effective postnatal care to a nursing mother are of very great importance to reproductive healthcare. Nigussie, et al (2004) observed that safety of mother and child even after pregnancy period depends highly on delivery care during pregnancy. This is not often available in Nigeria and poses great developmental challenges in achieving the Millennium Development Goals MGDs in Nigeria.

Black et al (2008) attributed the main causes of neonatal deaths (deaths of infants within the first 28 days of life) to acute respiratory Infections, Measles, Malnutrition, Diarrhea and Malaria among others. Charmarbagwala (2004) in his finding estimated that 37% of neonatal deaths in Nigeria in 2003, were due to infection (severe infections including pneumonia, sepsis, neonatal tetanus and diarrheal diseases) while preterm birth and birth asphyxia were estimated to account for another 49% of neonatal deaths. He also confirms that Socio-economic factors, (parental education, income, water and etc), Biological and demographic factors, were responsible. He further stated that the provision of health services account more significantly towards a child's health than even socio-economic conditions. The Canadian Health Network (2011) agrees with the above factors but added genetic endowment as an additional factor.

With the country's high maternal mortality ratio and high rates of neonatal, infant and under –five mortality, pregnancy, delivery and survival remain high- risk venture for Nigerian women and children. UNICEF (2007) declared that many adverse reproductive health conditions are actually reflective of and have implication for human rights violation. Viewed from human rights perspective, for example, maternal mortality, which is largely a preventable tragedy, reflects a violation of the rights of the woman to life. It is a violation of the pregnant woman's right to maternity and health as the universal declaration of Human Rights states in article 25 that "Motherhood and childhood are entitled to special care and assistance as it has been found that less than 20 per cent of health facilities offer emergency obstetric care and only 35 per cent of deliveries are attended by skilled birth attendants. Furthermore, an additional observation that the degree of these causes differs from society to society was also made. However, timely intervention by trained personal with provision of appropriate facilities and care will alleviate the above causes and prevent/ reduce mortality.

Health Care Policy in Nigeria

Maternal and Child Health Care Policy is embodied in the National Health Policy and Strategy to achieve health for all Nigerians. The policy was introduced in 1988 and revised in 2004. The policy founded on egalitarianism, seeks to improve the health of all Nigerians by devising a sustainable health system based on primary health care (PHC) that is promotional, productive, preventive, restorative and rehabilitative. Nnamuchi (2007) observed that the policy was expected to ensure a socially and economically productive and fulfilling life to every individual. Accordingly the Federal Ministry of Health (FMOH) is responsible for policy and technical support to all health system nationally through the National Health Management Information System and the provision of health services through the tertiary and teaching hospitals and national laboratories. The State Ministry of Health (SMOF) is responsible for secondary hospitals and for the regulation and technical support for Primary Health Care Services (PHCs), while the Primary Health Care is the responsibility of the Local Government where Health services are organised through the Wards. Each local government is sub-divided into 7-15 Wards. However; there is often duplication of roles and responsibilities among the different tiers of government and Agencies /Departments within the FMOH and States Ministry of Health (SMOH) as a result of non continuity by succeeding governments of programmes initiated by previous governments. Succeeding governments prefer to jettison the existing health policies to develop new ones. This often creates confusion as it has caused disaccord in the health care activities of government in Nigeria. The implication of which are weaknesses in coordination and tracking performance and bench marking. Nigeria adopted all international health care intervention programmes but does not seem to have properly articulated its health policy development programme.

Theoretical Framework: The Elites theory of Mills (1956) is used in our argument in this work. Mills postulates that all political power is held by a relatively small and wealthy group sharing similar values and interests and coming from relatively similar privileged backgrounds. He argued that the structure of institutions were such that those at the top of institutional hierarchy largely monopolized power. In his analysis, the bulk of the population was pictured as a passive and quiescent mass controlled by the power elite, which subjected instruments to psychic management and manipulations. This theory is appropriate for this study as it illuminates elites' or management's negligence in the administration of the Maternal and Child Health Policy. This paper assumes that ineffective management stifles the availability and accessibility of MCH services particularly to the most vulnerable groups. Like various development policies in Nigeria often launched by political elites, the Maternal and Child Health Policy with robust policy intensions does not seem to have so far positively impacted on the masses as expected. It seems that inefficient management of the health sector by leaders did not promote maternal and child health services to the detriment of the quiescent masses.

METHOD OF STUDY

The paper adopts the analytical framework in its discussion. In Rivers State women in the reproductive age constitute 55.55% of the female population (National Population Commission 2006). Data for the study was generated from both primary and secondary sources such as personal interview/discussions and observation. The secondary data relied on materials such as gazettes, policy frameworks, extant laws, resolutions, publications, and seminar/workshop/ professional papers presented at national and international conferences, and lead documents on health by Federal Government of Nigeria, World Health Organisation as well as internet documents on the subject matter. The study utilized the purposive sampling method in selecting three communities for the study from which 10 respondents each were purposively drawn for the study. This was to enable the researcher include relevant sample/respondents for the data. A total of 30 women within child bearing age of 18-49 who utilized government health facilities were thus randomly drawn from the study area. Also a total of 10 administrators /medical personal such as head of departments of public hospitals in study areas were randomly interviewed bringing the number of total interviewee's to 40 respondents. (See appendix).

STUDY AREA: The scope of the paper covers Rivers State of Nigeria. Rivers state also known simply as Rivers is one of the 36 states of Nigeria. The inland part of Rivers State consists of tropical rainforest, towards the coast the typical River Delta environment features many mangrove swamps. The National Population Commission (NPC: 2006, 2009, and 2010) put the state population estimate at 6,6.l89,087 making it the 6th most populous state in the country. Its capital, Port-Harcourt is the largest city and is economically significant as the centre of Nigeria's oil and gas industry where about 90% of the Country's earnings are harnessed. Rivers is bounded on the South by the Atlantic Ocean, to the North by Imo, Abia and Anambra, to the East by Akwa Ibom State and to the West by Bayelsa and Delta States. It is made up of three senatorial zones and presently has 23 local government areas (RIVEEDS: 2006). The study focused on three rural communities, each from one local government drawn from each of the three senatorial zone of the state. Thus the following communities/ the local government areas/ were randomly selected to include; Tamuna Ama in Ogu / Bolo Local Government of Rivers East Senatorial area, Okoloma Ndoki of Oyigbo Local Government of Rivers South East senatorial zone and Umunachi of Omuma local Government in Rivers West Senatorial zone respectively. The surroundings of the sampled communities are characterized with features of lack of maintenance as shown from the dilapidated public Health service infrastructures and facilities and subsequent poor maternal health outcome.

FINDINGS /ANALYSIS OF HEALTH POLICY ON MATERNAL / CHILD HEALTHCARE IN RIVER STATE

60% of the interviewees in the three Senatorial Zones (Rivers East, Rivers South East and Rivers West) revealed that most of the hospitals /clinics were not good enough to be hospitals. Observation corroborates their perception that the facilities were either obsolete or non-existent.

The result further shows that trekking time to the nearest hospital took about one hour-one and half to access. This is because the health facilities available are not sufficient to cover reasonable level of health need for the entire state with the implication that inaccessibility and inequality to health care facilities in people's access contribute to maternal/ child mortality and level of well being. Moreover, political choices and social organisations that distribute power and resources unequally across population reproduce unequal health outcomes.

The study result also established that corrupt practices of many health sector administrators make service delivery to be difficult to access. They either divert allocated resources or receive bribe from patients before treatments are given for treatments meant to be free. Medical personnel also use the strategy to recommend patients to their private practice sector. This is closely related to the finding that some senior consultants in government owned hospitals are hardly seen on duty due to engagement in their private hospitals. Inexperienced student Doctors are thus often left to handle serious obstetric cases. This has led to maternal and Child morbidity and mortality. Such practices need to be checked by appropriate quarters to stem the level of corruption in the health service sector. Also discovered was that 30% of pregnant women from the senatorial Zones investigated made use of antenatal and medical delivery services. On the other hand, 70% of them (expectant Mothers) agreed that they preferred the Traditional Birth Attendants (TBAs) to take their deliveries. They claimed they patronised Traditional Birth Attendants, friends and relations to attend to them at home and in church premises rather than using the hospital personnel. This according to them was because the cost was borne by individuals at same cost; so whether one was rich or poor did not matter, thereby introducing inequality in terms of access and cost in health care delivery. It was found too that the behaviour of medical health care providers also scares them from patronizing medical health facilities. Thus with limited access to antenatal services many children are born under weight (below 2.5kg) jaundiced, malnourished and anemic. This clearly establishes the positive relationship between unskilled attendants and the occurrences of maternal deaths. Also where health seeking behaviour is inadequate, access to health service is limited as most mothers are poor, illiterate and rural dwellers, with the strong positive association that has been shown to exist between level of care obtained during pregnancy and the use of safe delivery care, antenatal care also stands to contribute indirectly to maternal mortality reduction.

Finding also pin points that 70% of those interviewed are of the view that inadequacy in food and nutrition which is the benchmark of a healthy people have become far away from the reach of the ordinary Nigerians particularly in these recession times.
The study further revealed that high maternal mortality rate corresponds with high neonatal rate in the Study areas which are the low resource settings of Rivers States. Also established was that level of education and the health care received from mothers are positively related.
In summary the study highlights the challenges faced in maternal and child health policy in rivers state to include the following:

Corruption: Corruption which has long taken a comfortable root in the fibers of the Nation's economy, cannot be over emphasized as a cause responsible in both maternal/ child health care delivery in the study areas. A higher percentage of the medical personnel/ administrators interviewed agreed that corruption reduces the level of resources and investments available for the public health system on which most vulnerable populations are more reliant on. In addition, a larger number of discussants accepted that corruption delays and reduces the vaccination of New-born, discourages the use of public health clinics and reduces satisfaction of household with public health clinics. Nekari and Oni (2012), Hussmann (2011), Gupta et al (2002) are all in agreement that corruption deprives people of access to health care and leads to poor health outcomes. Workers may also demand brides to either queue jump or for medications which ought to be free. More so, corruption cost lives when adulterated drugs are administered. Stolen funds also hamper efforts to beat major health challenges, such as could arise from maternal/ child health care.

Cost: A major reason many people are not utilising available health care service is **cost**. 60 per cent of interviewee's in the study cited cost as the impeding factor in their access to health care. 70% of Nigerians live below poverty line. UNICEF, UNFPA, WHO and USAID (2015) noted that PHC centres performed abysmally in most areas of maternal and health Service and attributed the existence of poor and several challenges in service delivery to include high cost of contraceptive commodities, inadequately equipped service delivery points, high attrition of trained service providers, and high level of unmet needs for family planning and inadequate linkage of adolescent reproductive health services to regular health service delivery system.

Poor access to health facilities: Accessibility to health care outfits in terms of distance including poor roads and lack of transport facilities, lack of essential skilled workers as well as equipment and drug supplies, infrastructural problems, lack of portable water and irregular electricity supply are all impediments to MCH policy execution in the state as was established by this study. In Okoloma community it was observed that there is complete absence of hospital and health Centres. This

corroborates the report of Business Day (2015). TBAs /mothers interviewed attributed cause of deaths to witch crafts manipulations, bad lack and the likes. This is a serious challenge. Such perception is due to the low level of education of the TBAs and mothers. Again another revelation of this study is the problem of going a long distance before getting a Healthcare facility. For instance expectant mothers particularly those in the riverside areas have to travel a long distant before accessing a maternity.

Lack of Funding/ Improper Implementation of Health Policy: Lack of fund,absence of sufficient qualified medical personnel, non availability of modern investigative equipment and back-up infrastructures are some other obstacles tosuccessful implementation of the Maternal/child health care policy and the subsequent maternal and child survival in the state.

From discussions on findings above, it is established that the policy on maternal/ Child health care in Rivers state (which ought to be an accelerator of rural development) has not achieved the goals for which it was set to attain leaving the sector in a serious jeopardy.

CONCLUSION

Nigeria has developed a number of policy documents that could propel effectiveness and efficiency in the health sector, yet the overall maternal and child health status of Nigeria remains poor. An evaluation of the implementation of the National Policy on Reproductive Health and the National Strategic Framework on health (2001) concluded that Nigeria's maternal and Child Health system remains weak and the policy has not been successfully implemented and monitored. This is also replicated by this study. The way forward is an improved attempt in the implementation of the health policy programmes.

RECOMMENDATIONS

To improve Maternal and Child Healthcare Service, the following recommendations are proposed:

Mothers and expectant mothers should be sensitized on the importance of paying regular visits to the maternity wards to enable them access the right health care. Antenatal and postnatal counseling should centre on hygiene, and adequate feeding. Pregnant/ nursing mothers should be told about the dangers inherent in the consumption of processed foods and drinks among others. Therefore, holding special maternal and child health clinic should be organized regularly to enlighten expectant mothers on the need to patronize proper health care. Education is critical to Maternal and Child Health. Parents should encourage their young daughters to acquire knowledge before marriage. Ability to read and write also reduces the occurrences of morbidity and mortality rate.

Every Nigerian irrespective of socio-economic status or geographical zone should have access to quality health care services.

Stringent measures should be put in and implemented to bring corrupt officers to book.

Women should be empowered economically to be able to take care of their needs and enhance their economic base as well as that of their communities.

Functional Infrastructure should be provided in public hospitals. Traditional health givers should be retrained for better performance. If the goal of the government is to achieve health for all citizens, much still has to be done to reduce the challenges associated with access to health care facility. Health care should be made accessible to the citizens in every nook and cranny of the country by giving priority to the development of primary healthcare system.

The risk of maternal and infant mortality and pregnancy related complications and death can be reduced by increasing access to quality preconception and conception care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disabilities and enable children to reach their full potentials.

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Appendix 1: Table 1. Composition of the Sample for focus group Survey (Interview)

S/N	Community Sampled	Local Govt. Area	Senatorial Zone	Sub-total
1.	Tamuna Ama	Ogu/Obolo	Rivers East	10
2.	Okoloma Ndoki	Obigbo	Rivers South East	10
3.	Umunachi	Omuma	Rivers West	10
Grand Total				30

Source: Field Survey:2017.
Table 2.

Sampled Distribution for Interview of Medical Personnel/Management Personnel

S/n	Name of Health Facility	Number of Respondents
1.	Model Primary Health Centre	3
2.	First Rivers Hospital Limited	3
3.	Save A Life Mission Road	2
4.	Braitwait Memorial Specialist Hospital	2
	Total	10

Source: Survey Interview 2017.