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Review Article

Reproductive Health Standards in Sub-Saharan Africa: A Critical Overview of Policy and Administrative Gaps by Acheoah Ofeh Augustine, International Relations Analyst, University of Lagos, Nigeria

Acheoah Ofeh Augustine*

Department of Political Science, University of Lagos, Nigeria

***Corresponding Author:** Acheoah Ofeh Augustine, Department of Political Science, University of Lagos, Nigeria.

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Abstract

This paper attempts a discursive perspective on reproductive health challenges in Sub-Saharan Africa, particularly on how it affects Maternal Mortality Prevalence (MMP), the availability of safe contraceptive medications, the prevailing trends on forced and under-age marriages as well as how poverty and low income economic statuses of many households serve to endanger the lives of thousands of expectant mothers as well as infants in their first five years after birth. The paper concludes that there are non-medical and non-scientific perspectives to the challenges to accessing quality reproductive health by millions of women in Sub-Saharan Africa. Among these extra-medical factors are cultural, religious and social climates (Wars and Armed conflicts) manifestly in sexual violence, forceful pregnancy, genital mutilation and abuse, unconsented marriages among many. The paper concludes that while inter- governmental partnership is required to address the challenges of poor reproductive health, International non-governmental Organizations and NGOs should be concerted to forge a unified focus on the campaign for effective reproductive health care delivery in sub-Saharan Africa.

More than 300 million of Africa's 730 million 'projected births through 2030 will not be attended by skilled health personnel. 65 per cent of women with an unintended pregnancy were as a result of non-use of contraceptive or reliance on traditional methods (Such as withdrawal or Calendar-based method)-(WHO 2019). About 3,192 000 children who survive their first month of life after birth die before their fifth birthday accounting for half of global maternal and child death (13000 deaths per year). Furthermore, Faith-based Organizations and Traditional Institutions that are the repositories of traditional and cultural values of most African societies should be co-opted in the campaign against cultural practices and religious beliefs that endanger the reproductive health of today's African women and girls. On the national fronts, the governments of African states should increase budgetary allocations to health sector for healthy citizens make up healthy nations.

Keywords: Maternal Mortality Prevalence; Reproductive Health; Budgetary Allocations; Faith-based Organizations; Sub-Saharan Africa; INGOs; NGOs; Extra-Medical Factors; Repositories

Introduction

The quest for safe and quality medical cares for women and girls of reproductive age in sub-Saharan Africa had remained a central theme in the broader health care policies in sub-Saharan Africa where over 90 per cent of maternal deaths occurring in developing countries (536000 girls and women) are recorded; where one thousand women die per 100,000 live births; and where the lifetime risks of maternal deaths is 1 in 22.

While reproductive health is majorly biological in nature, there are socio-biological behaviors that also endangers the lives of women of reproductive age (15-49)such as: rape, armed hostilities which lead to the destruction of basic amenities such as hospitals, water, shelters, as well as religious and cultural practices such as early marriages and forced circumcisions. Poor literacy levels also blight the chances of women and girls in making rational and safe choices on health related issues (Acheoah, O.A 2019).

This paper seeks to periscope the reproductive health challenges and policy gaps on the part of national and international community in their responsiveness to the dangers facing millions of women of reproductive age in sub-Saharan Africa. The health statuses of married women have direct impact on the survivability of millions of children under age 5. The paper looks through the

myriad of attributing factors: economic, social, political, cultural and religious factors and suggested the way forward.

Objective of the paper

The paper spotlights the factors responsible for poor material health care service delivery in sub-Saharan Africa. Categorically, the paper attempt a discursive perspective on policy failures and program gaps as well as their implications for the survivability of expectant mothers and the children of nursing mothers in the early years after birth. While policy priorities and partnership with NGOs and INGOs is critical, the intellectual front in the crusade against the dangers that threaten today's African girls, children and women is indispensably a complimentary objective this paper attempts.

Research questions

This paper is poised to interrogate the following trends endangering the productive health of women in sub-Saharan Africa:

1. What sociobiological/hypersexual behaviors are endangering the reproductive health of women of child bearing age in sub-Saharan Africa?
2. Why are the Governments of sub-Saharan Africa lagging behind in policy and program intervention towards mitigating the health hazards face by millions of women in the region?
3. What health indicators reveal the implications of policy gap on reproductive/Child-Maternal health care delivery in sub-Saharan Africa?
4. How can these health challenges be addressed in the region, the way forward.

Empirical reports on reproductive health indicators in sub-Saharan Africa

UNFPA (2015) found that early progress in adolescence fertility, inadequate distribution of contraceptives as well as unmet family financial needs as some of the challenges. The disparities in sub-Saharan Africa were linked to socio-economic background age, urban versus rural dwellers.

Hodges Borg and Aaby (1992) linked AIDS epidemics to the organization of the family and reproduction. Klissou (1995) noted that between countries situations may vary widely but some broad guidelines can be discerned as African societies are polygamous marriages which vary among countries. The proportion of married women in polygamous union is more than 50% in Togo (Agounke *et al*., 1989); 97.57% in Burkina Faso (Klissou, 1995); 36% in Nigeria (Kourgueni *et al*., 1993); 14% in Rwanda (Barrere 1994). These proportions increased with age and decreases with educational levels and higher in rural setting (DHS Survey)

Hogsborg and Aaby (1992) found divorce rate as high as 30 to 40% in Guinea Bissau while (Klissou, 1995) cited post-natal abstinence as the main reason for polygamy and a father in the increased member of sexual partners. Marianne Hogsborg and Peter Aaby (1992) observed that some groups in Bissau where abstinence was generally observer (approximately, 80% of respondents reported having remained abstinent throughout breast feeding that it was associated with an increase in the member of extra-marital partners as men turned to other sexual partners during breastfeeding.

Men have been consistently reported to have engaged in extra-marital sexual intercourse than their women counterpart (Careal, 1995), in urban Nigeria, over half the men and women in 5 reported having had extra-marital coitus (Isuigo Abanihe, 1993), a figure which vary with family, education and religious affiliation.

Asiugo-Abanihe (1993) reported that monogamous married women are more than their polygamous counterpart because their husbands are not shared. Acheoah A. O. (2019) noted that most young husbands in Nigeria denied their young wives the needed child spacing due to high levels of promiscuity among the women with a view that spacing their wives might make them sexually attractive to young men who go after married women and by this process many young women are endangered. The mode of fashion among young women have also been found to contributing to the high rates of extra-marital sexual practices as is the rising rates of unemployed married men who lose the economic power to sustain their homes. Acheoah, O. A (2019) found 70% of Nigerian women wanting men that can maintain them (meet their physiological and social needs), for these, many among whom can go extra-martially to meet their needs. The idea of non-spacing children among Nigerian men is to deny their wives the chances of running out of marriage after first or second child birth.

While maternal deaths are caused by diverse factors, the four major causatives are:

1. Severe bleeding (post-partum);
2. Infections (majorly after delivery);
3. Hypertensive disorder in pregnancy (eclampsia); and
4. Obstructed labor.
5. Meanwhile, post-abortion complications have been linked to13 percent of maternal death cases and collectively, these factors are responsible for 80% global cases of maternal deaths (AFRICA Progress Panel Report, September, 2010).

According to the report, 57 countries across developing world have critical shortages of midwives, nurses and doctors, where also, the services of 2.4 million health workers are critically needed. In Nigeria, there are intra-regional inequality in maternal-child

care health service delivery among women in rural and their urban counterpart. On government expenditure levels for health care, a survey by the High Level Task Force on Innovational Financing for Health System, (2009) $54 per capita a year is an absolute minimum to provide essential services. In 2018 and 2019, Nigerian government allocated. 94% of all maternal deaths worldwide occur in lower-middle income countries as sub-Saharan Africa accounted for approximately 86% (254000) of the estimated global maternal deaths in 2017. The region also accounted for roughly two-thirds (196000) of maternal deaths, while Southern Asia accounted for nearly one fifth (58000) (WHO 19 September, 2019 Maternal Mortality Report)

A survey in Nigeria found a third of sexually active men and women claimed to have had at least one course of treatment for an STD (Orubuloye et al., 1994). Analysis of contraceptive prevalence rates (CPR) in the Africa (Ethiopia, Malawi and Rwanda found an animal increase in CPR of women of reproductive age as distributed:

1. 2.3% in Ethiopia (2005-2011);
2. 2.4% in Malawi (2004-2010); (Source: DHS, Married Women of Reproductive Age, 2013).

In Malawi, 26% of married women use injectable female sterilization while 10% chose modern methods of child spacing (UNDP, Malawi Ministry of Development Planning and Cooperation, 2012). Teenage pregnancy rates is as high as 26% of all Malawian women aged 15-19 years which were pregnant or have delivered a child. Fewer younger Married 26% of 15-19 year old than older women (49% of 35-39 years old practice family planning (Malawian Ministry of Health, 2012); World Population Datasheet (2011); Demographic Health Survey (2011).

In sub-Saharan Africa, 1 in 16 women face the lifetime risk of maternal mortality with varying disparities among the constituent nations:

1. In Niger it is 1 in 7;
2. In Sierra Leone it is 1 in 8;
3. Nigeria recorded 1 in 9.

In sub-Saharan Africa, women of age 15-49 are prone to pregnancy related complications due to multiple factors among which are poverty, poor national health education, cultural and religious practices. HIV/AIDS remained one of the biggest social and medical threats to families as millions have been orphaned. Early forced marriage and genital mutilation are two major threats to reproductive health in sub-Saharan Africa. Poor maternal care skills are prevalent in 11 sub-Saharan African countries where incidentally, there are high cases of infant and maternal mortality in per 1000 live birth. Between 1990 and 2005, sub-Saharan Africa is the only region where appalling increase in maternal mortality was recorded (a rise in fertility rate in the region from 7.7 children per women in Niger to 2.0 in Mauritius).

South Africa recorded 56% of maternal mortality incidences between 24 and 230 deaths per 100000 live births. WHO (2007) noted that women from poor homes are more likely to deliver at home without the attention of skilled medical personnel. Moreover, the women from these low income countries are also prone to unsafe contraceptive to induce delay in birth delivery at home. In conflict prone regions, many health specialists fled as is in South Sudan with a consequent increase in gender-based violence. In D.R. Congo, Central African Republic, Chad, Burundi the stories are not different as women and young girls continued to be subjected to forceful pregnancies and HIV/AIDS infestations. (Malawian Ministry of Health, 2012); World Population Datasheet (2011); Demographic Health Survey (2011).

In D.R. Congo, there were rising trend of sexual violence with thousands of Congolese young girls and women facing vagina fistula medical disorder, with tissue tears found in their virginas, bladders and rectums after being subjected to rape. Meanwhile, limited access to maternal medical care worsens the plights of women of reproductive age in the conflict torn regions of sub-Saharan Africa.

Over half a million women in rural areas and urban slums die during pregnancies and childbearing, 99% of which occurred in developing countries (WHO Report 2004). For every woman who dies as many as 30 others suffer chronic illness or disability. About 270000 pregnancy-related deaths occur annually in sub-Saharan Africa with Nigeria, Benin, Burundi, Cameroon, CAR, Cote d'Ivoire, Senegal, Somalia, Tanzania, Guinea Bissau, Ghana, and Rwanda experiencing a high Maternal Mortality Rates (MMR) as high as 500 per 100000 live births in 2005 (WHO Report, 2004).

Among the identifiable causative factors are:

1. Un-planned pregnancies;
2. Poor medical facilities;
3. Inadequate and inappropriate budgetary allocations to health sector as a component of national annual budgets;
4. inadequate personnel in the sector;
5. Incessant industrial actions due to un-paid back lodges of salaries and arrears owned to practitioners in the public health sector;
6. Low literacy levels among girl child and married women of reproductive ages.

Although, the number of maternal mortality records is higher in Asia; neonatal deaths were higher comparatively in sub-Saharan Africa where one in five women risks losing a baby during her life-

time in relations to one in 25 women in developed and advanced nations of the world. Meanwhile, one in five maternal deaths worldwide occurs in three sub-Saharan Africa countries of which Nigeria alone accounting for 1 in 19 deaths in the region. Collectively, Niger, DRC and Nigeria account for two thirds of all maternal deaths in Sub-Saharan Africa (WHO, 2007). Among the five leading sub-Saharan African countries with high Maternal Mortality were:

1. Angola 1000;
2. Burundi and Malawi, 1100
3. Rwanda 1400;

Six African countries have lifetime maternal death risk of 1 in 5 with Angola and Somalia recording the highest lifetime risks (1 in 12) while Mauritius recorded (1 in 3,300) comparable to advanced countries. Reports show that between 90 to9 5% of women in Ethiopia deliver at home living two hours or more away from public health maternal child health facilities (WHO, 2017).

UNICEF (2008) reported bleeding as the major cause of maternal deaths which kills both the wealthy and poor alike within two hours of birth if unattended to. Half of the deaths caused by hemorrhage in Sub-Saharan Africa predominantly in rural areas where there are poor medical cares. UNICEF identified political will among member states as central to fighting the scourge…that in countries where the trend has reduced: Thailand, Malaysia, Sri-Lanka, Egypt and Romania considerable investment in maternal health facilities have been made and children who lost their mothers have three to 10 minutes higher risks of dying than those living with their parents.

Nigeria alone recorded 6 million births in 2007 with a total fertility rate of 5.4. A 2018 report shows that Nigeria has the highest population of the world's extremely poor population with over 75 million living on less than $1.5 dollar a day, surpassing India as well as having the highest global prevalence of out of school children (13 million). According to UNICEF estimates in 2005 average the national mortality ratio at1000 deaths per 100000 live births lifetime maternity mortality deaths at 1 in18 approximately 1 in every 9 maternal deaths globally occurs in Nigeria. According to survey between 100000 and 1 million women in Nigeria suffer from obstetric fistula with a neonatal deaths of 249000 mortalities with 76% of this neonatal period of occurring in the first week of life (WHO, 2004).

Socio-economic statuses and wellbeing have been adduced as major factors in accessing maternal child health care in sub-Saharan Africa. Save for Chad, Mali, Mozambique, Uganda where trained doctors and nurses attended to women, many others such as Ethiopia were the lowest number of skilled birth attendance in sub-Saharan Africa. There is a key ole child education plays in the social choices they make when they become adults as wives in reproductive decisions they take and how these decisions change their lifetime statuses as mothers. Girl Child education is central to the campaign against early child marriages (under18) as (WHO, 2004) reported South Africa as recording as high as 400 MMR per 100000 live births.

Early and Forced marriages are higher in Mali and Niger (75% in Mali and Niger) –UNICEF, MMR 2004, Delivering in Good Hands MMR updates. Africa's population is projected to reach 1 billion by 2055, prospectively the highest of any single region in the world. From 2017, sub-Saharan Africa emerged the region with the number of child births, a trend projected to remain through the rest of the Century (2099). More than 300 million of Africa's 730 million projected births through 2030 will not be attended to by skilled personnel. Under age 5 mortality rates in sub-Saharan Africa decreased by 58 per cent between 1990 and2017, nonetheless, over half of the world's 5.4 million under five deaths in 2017 occurred in Africa (WHO, 2018).

According to UNICEF, 85 percent of all deaths in children under age 15 occurring among children younger than 5, in 2016, Pneumonia, Malaria and diarrhea accounted for 36 percent of all under-five deaths in Africa. 31 million under-five deaths will occur in Africa between 2018-2030…if all countries at risk of missing the SDG's target on under-five mortality achieve the target 8 million lives could be saved in the region.

Due to demographic dynamics characterized by growing population, Africa requires an additional 4.2 million health workers about current growth to meet WHO's minimum standards on increase of 1.3 million primary school teachers to meet the best sub-regional performers pupil-teacher ratio (UNICEF, January, 2019 Report).

Nearly 4.7 million mothers' newborn and children in sub-Saharan Africa (265000) die yearly due to complications of pregnancies and child births as 1,208,000 babies die before 30 days after live-births. About 880,000 babies born in sub-Saharan Africa are out of the states' health policy program covering child-maternal health care delivery. Non pregnancy related infections such as HIV/AIDS and Pneumonia accounts for 23% of deaths and unsafe abortions accounts for 4% of maternal deaths in Africa (UNICEF State of the World's children 2010, New York, UNICEF 2010).

According to WHO (2019) the family planning study of more than 10000 women aged 15 to 49 across 36 low and Middle income counties indicates that 65 per cent of women with an unintended pregnancies were as a result of the non-use of contraceptive or reliance on traditional methods (such as withdrawal or calendar-based methods). There is a rising trend and cases of unplanned

pregnancies at 74 million women in low and middle income countries where unintended pregnancies occurred yearly resulting in some 25 million unsafe abortions and 47,000 maternal deaths annually (WHO, 2019).

Complicated pregnancies and child births are the leading killers of adolescents girls aged 15 to 19 (UNFPA, 2019) as they face impeded access to vital reproductive care health information and service. About 2 million unplanned pregnancies occurs yearly resulting in some 600,000 unsafe abortions with one in four pregnancies unplanned, two thirds of women forgoing contraceptives (UNICEF 2019).

The MDG "Goal 5" was largely unaccomplished in sub-Saharan African countries where about two thirds of the total maternal death victims (210,000) deaths occurred in 2015. Goal 5 was reincorporated into the SDGs as a policy towards reducing the prevalence rates of Maternal Mortality (MMR) to less than 70 deaths per 100,000 live births by 2030.

Available reports indicate that there are scarcities of opportunity for reproductive and maternal health opportunities for women and girls in maternity care, birth delivery attended by skilled personnel, school attendance for girl child with early marriages as major bane to adolescent mothers. 500 million women or about half the population of the region's (SSA) population and 14 percent of the female population worldwide are in Africa with 47 per cent of them within the reproductive ages of 15-49.

In spite of the unified policy focus by the international community under the MDGs "Goal 5", on maternal health, about 546 maternal deaths per 100,000 live births, representing about two-thirds or 201,000 of the total global maternal deaths (300,000) were recorded in Africa in 2015 (WBG Global Report 2018). Among the associated targets of the MDG 5 includes a reduction in MMR by 75 per cent each years by the then 189 member nations of the UN, however, between 1999 and 2015, the international health policy objective was largely unachieved in Low and Middle Income Countries (LMICs).

The universal access to contraceptive methods, the second associated target of MDG 5 had remained an elusive reproductive health objective for women in sub-Saharan Africa (15-49 years of age) resulting in high prevalence rate of unwanted pregnancies and unsafe abortions and ultimately deaths. The successor blueprint to the MDGs, the SDGs, incorporated the targets of ending preventable maternal mortality by a-70 percent reduction per 100,000 live births by 2030 (SDG target 3.1 of SDG 3). SDG 3 (3.2) targets to end preventable deaths of newborn and children under five years of age with all countries enjoined to reduce neo-natal mortality to as low as 12 per 1000 live births. Target 3.7 seeks to ensure universal access to sexual and reproductive health care services including family planning information and education and the integration of reproductive health themes into national health programs.

The MDGs before the SDGs had sought under "Goal 4" to reduce child mortality and Goal 5 sought to improve maternal health, however, the 2015 baseline saw global Maternal Mortality rates standing at 216 deaths per 100,000 live births; under-5 mortality rate stood at 43 deaths per 1000 live births while neo-natal rate globally stood at 1000 live births in 2015 (WBG 2018 Report).

By 2015, approximately three in four women of reproductive age married or in union met their needs fir family planning through contraceptive methods. While MDG 2 sought to achieve universal primary education by 2013, about two thirds of adults who were illiterate were women globally as one in ten girls were out of school amounted to one in 12 boys; children from the poorest 20per cent of households are nearly four times more likely to be out of school than their richest peers.

SDG Goal 4 seeks to address the gap between expectation and realities by eliminating gender disparities in education and ensure universally, equal access at all levels of education and vocational training for the vulnerable including persons with disabilities. In sub-Saharan Africa alone, 56 per cents of births are attended to by skilled health personnel in rural communities while the attendance rate is 80per cent among urbanite women (Implying a regional disparity in health care delivery system).

Domestic violence is one of several socio-biological behaviors endangering the reproductive health of girls and women of child bearing age (15-49). Africa recorded the highest prevalent rate with 36.6 percent in both intimate partner and non-partner sexual violence to women of age 15 and above. This phenomenon is reinforced by the prevailing socio-cultural behaviors of the society particularly in sub-Saharan Africa where women account for 58 per cent of the region's total population living with HIV with about 380,000 women as new carriers of the Virus (between ages 10-24). As the disease spreads, only 15 percent of girls of adolescent age have acute knowledge about the disease.

The nutritional statuses among women of reproductive age, expectant mothers and nursing mothers are also a major drawback and determinant of reproductive health standards. About 468 million women aged 15-49 years worldwide are anemic and between 48 per cent and 57 percent of them are in sub-Saharan Africa. Anemia results from multiple factors ranging from poor nutrition, hormonal disorders or cancer as well as Malaria parasite which could

lead to postpartum hemorrhage in pregnancy and ultimately in maternal mortality.

Globally, 85 percent of pregnant women living with HIV live in sub-Saharan Africa while HIV prevention and treatment during pregnancy to protect pre-natal transmission of the disease is elusive to 1.3 million expectant mother carriers of the disease in Low and Middle income countries. About 10,000 pregnant women and 200000infants die every year from malaria infections urging pregnancy. The WHO recommended the Intermittent Preventive Treatment of Malaria in Pregnancy (IPTPs) with Sulfadoxine –Pyrimethame (SP) as beign the most cost-effective medical interventions for mothers under malaria attacks while pregnant (WHO, 2014).

Meanwhile, neo-natal deaths rose globally by 45 per cent of under-five deaths resulting in 2.7 million deaths annually with over 80 percent of the newborn deaths caused by three preventable and treatable conditions:

1. Intra-partum related deaths (births asphyxia);
2. Complications resulting from prematurity in fetuses; and
3. Neo-natal infections.

As mitigating remedies, the World Health Organization recommended that nursing mothers to seek ante-natal special care within the first 24 hours immediately after birth and when the delivery occurred at home, the mother and baby should be taken to the nearest maternal health facilities. Post-natal care must thematically incorporate appeal for exclusive breastfeeding, birth spacing and contraceptive methods.

Nursing mothers are further advised by the World Health Body (WHO) to seek extra-neo-natal care between seven to 14 days after birth and six weeks after parturition (as encapsulated in the SDG target 3.2): "to end preventable deaths of newborns and children under five and maternal health policies aimed at reducing neo-natal mortality rate to as low as 25 per 1000 live births, a figure that was 19 deaths per 1000 live births globally in 2015 hence the new blue print's ambition".

Definitional perspectives

1. Maternal mortality Rate: this is the number of women who die from pregnancy related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births (WHO 2018);
2. Infant Mortality Rate is the number of infants dying before reaching one year of age per 1000 live births in a given year (WHO 2018)

Meanwhile, political instabilities also endangers the lives of millions of children, girl and women in general, a trend that traumatizes women and children in conflict torn African countries such as Sierra Leone until recently, D.R Congo, South Sudan and North East Nigeria where thousands were subjected to rape, kidnapping and humanitarian crises. Sub-Saharan Africa had over a billion populations with 23 percent being adolescent between age 10 and 19 years, constituting 11 percent of the region's population (the highly sexual active population).

While the region realized a 4 percent reduction in fertility rate between year 2000 and 2015, the current trend saw a-102 births per 1000 adolescent girls with the implication being far reaching:

- They are by this trend exposed to greater risks than older mothers during pregnancy cycles and after births;
- In social terms, adolescent pregnancy truncates the prospect for education and skilled carriers for millions of affected girls which is an underlying causative to poverty among women population in sub-Saharan Africa;

There are more educational attainment in urban than in rural dweller. Adequate policy-program intervention on national and international fronts remained the way to go. Fiscal indiscipline among political elites who misappropriate funds voted for health sector and allow mothers to die of preventable diseases remained an artificial stumbling block.

Summary

Among the greatest challenges facing maternal, neo-natal, child and girl-child reproductive health in sub-Saharan Africa are:

1. Pregnancy and child birth complications;
2. Neo-natal illnesses;
3. Childhood infections resulting from unclean environments where open defecation, unclean water and sewage system;
4. Malnutrition and HIV/AIDS scourge
5. Socio-biological-hypersexual behaviors: rape, sexual violence, forced circumcisions;
6. Socio-Cultural and religious beliefs and practices: early child marriage, polygamous marriages, un-spaced child bearings due to lack of fidelity trust among spouses (couples) as a way to get the women's feet in marriages and check promiscuous conducts in marriages.
7. The failure of the Government to provide adequate funding, recruits and trained skilled personnel to give reproductive health care and infant primary health care for Children, girls and women of reproductive ages (15-45).

While the plans under the "SDGs 3" thematically on maternal health remains more aspirational than achievable in country like Nigeria where budgetary allocations to Defense Ministry surpasses those of Health and Education which are critical to achieving safe and sustainable reproductive health for women and girls. An edu-

cated girl child if her rights to consent is upheld and protected will be more rational in making marital decisions and choices (https://www.mondaqr.com/Nigeria/x/714318/fiscal+Monetary+policy / Highlighs+of+Nigeria+208+Approaved+Budget. Accessed, December 2019).

By sector, health sector ranks 187th of the 191 countries under WHO's health care delivery scale with 46 billion naira in health and 44 billion naira for the Basic Health Provision Fund BHOF) out of the N10.33 trillion naira appropriation bill (2020). The 2020 budget is lower than the N51.25bn andN55bn in 2029 and 2018. WHO reported one-third of Nigeria's health facilities destroyed with 3.7 million people in need of medical services. If these fiscal culture remains, the expected benefits of the SDGs "Goal 3" will remained a mirage as were the MDGs before them.

Socio-cultural campaign should be launched to sensitize the people through their traditional institutions, religious institutions and the media partners on the dangers of certain practices and the beliefs upon which they are underpinned on the health of women, girl child and children in general. A healthy region is the foundation of a wealthy and prosperous region, where the mothers of Africa are sickened and endangered by these factors, the entire workforce of the region, a catalyst for economic development will be in jeopardy [1-34].

Conclusion

What endangers the lives of today's mothers and girls of reproductive age (15-49) in sub-Saharan Africa are divers and multifaceted. While four major causes are strictly linked to medical complications during and after birth as well as infections:

1. Severe bleeding (post-partum);
2. Infections (majorly after delivery);
3. Hypertensive disorder in pregnancy (eclampsia); and
4. The dangers posed by cultural, religious and social climate are also critical. Sexual violence against women and girls in the heat of armed conflicts or social breakdown as well as early marriage practices are major social barriers.

Meanwhile, obstructed labors with post-abortion complications have been linked to13 percent of maternal death cases and collectively, these factors are responsible for 80% global cases of maternal deaths. Finally, the political front, inadequate budgetary allocations to health sector dashes the prospect of child-maternal health care delivery in sub-Saharan Africa. Only concerted efforts between all stake holders, governments, INGOs and IGOs aimed at forging a multilateral front on the dangers facing millions of women of child bearing age across the globe remains the way to forward.

Recommendations

This paper recommends that a holistic approach to the challenges be taken to addressing the dangers posed to women of child bearing ages (15-49). While government should increase budgetary allocations to health sector in general, specific attention should be laid thematically to child-maternal health care delivery. More nurses, doctors and midwives should be trained and drafted to health facilities in rural and urban areas based on population (on midwives per expectant mother-basis). Religious institution and traditional institutions should be concerned with on some religious and cultural practices that are life threatening to women of reproductive age. In armed conflicts, women and children the most vulnerable among conflict affected populations should be given special mandate focus by the UNSC to peacekeeping Missions and all extant UNSC Resolutions that seeks to protect women and children in armed conflicts must be observed and enforced to the letter.

Bibliography

1. Africa Progress Report. "From Agenda to Action: Turning Resources into Results for the People" (2010).
2. Bizuneh G, Shiferaw S, and Melkamu Y. Unmet Need and Evaluation of Program Options to Meet Unmet Need for Contraception in Ethiopia, 2000-2005: Further Analysis of the 2000 and 2005.
3. Bryce J and Reguejo JH. "Tracking Progress in Maternal and Child Survival". New York UNICEF (2010).
4. Clara Pons Duran, IS Global , Andrew Dabalem and Ambar Marayan, Poverty and Equality Global Practice, (2018).
5. DHS Analytical Studies No. 48. Rockville, Maryland, USA: ICF International.
6. Emhart P and Humuza J. Community-Based Distribution of Injectable Contraceptives in Rwanda: An Intervention to Reverse Rural Disadvantage. Washington, DC: Futures Group, Health Policy Initiative Task Order 1 (2010).
7. Ethiopia Demographic and Health Surveys: Calverton, Maryland: Macro International Inc., (2008).
8. Gwathin DR*., et al*. Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries. Washington World Bank (2007).
9. http://www.measuredhs.com/pubs/pdf/AS25/AS25[12June2012].pdf
10. http://www.unfpa.org/public/home/publications/pid/

11. https://dhsprogram.com/pubs/pdf/AS48/AS48.pd

12. https://www.google.com/search?q=WHO+REPORT+on+Reproductive+health+survey+in+Sub--Sahara+Africa&aqs=chrome..69i57.45263j1j4&sourceid=chrome&ie=UTF-8

13. https://www.google.com/search?q=WHO+REPORT+on+Reproductive+health+survey+in+Sub

14. Mekonnen Y, Bradley S, Malkin M, and WHO, World Malaria Report 2015 (2015).

15. https://www.mondaqr.com/Nigeria/x/714318/fiscal+Monetary+policy/Highlighs+of+Nigeria+208+Approaved+Budget

16. Nyirongo M and Akhter H. "Management Sciences for Health. Malawi: A Scale-up Case Study for Community-Based Access to Injectable Contraceptives, Presentation". International Conference on Family Planning, 2011, Dakar, Senegal, Abstract (2010).

17. Rapid Assessment of Adolescent Sexual Reproductive Health Programs, Services, and Policy Issues in Rwanda, Kigali, Rwanda: Ministry of Health (2012).

18. Religion and Reproductive Behavior in Sub-Saharan Africa DHS. Analytical Studies No. 48 by Charles F. West off, Office of Population Research, Princeton University, Princeton (2015).

19. Republic of Malawi National Sexual and Reproductive Health and Rights (SRHR) Policy, Ministry of Health. August (2009).

20. Rwanda Community Health Desk, Department of Maternal and Child Health, Ministry of Health, "Introducing Community-Based Provision of Family Planning Services in Rwanda: A Process Evaluation of the First Six Months of Implementation" Kigali, Rwanda: Ministry of Health (2012).

21. Solo J. Family Planning in Rwanda: How a Taboo Topic Became Priority Number One. Chapel Hill, UNFPA, Girlhood, not motherhood preventing adolescent pregnancy (2015).

22. UNICEF State of the World's Children 2010. New York; UNICEF (2010).

23. United Nations. "Goal 3", Sustainable Development", Knowledge Platform (2016).

24. United Nations. "The Global Strategy for Women's, Children's and Adolescents' Health". (2016-2030). Survive thrive transform (2015).

25. United Nations. Transforming our world: the 2030 agenda for sustainable development (2015).

26. Westoff Charles F and Kristin Bietsch. "Religion and Reproductive Behaviors in Sub-Saharan Africa" (2015).

27. WHO, UNICEF and UNFPA. "Maternal Mortality in 1995: estimates developed, by WHO UNICEF and UNFPA, Geneva: World Health Organization (2004).

28. WHO. Universal health coverage, (UHC). Fact sheet N°395 (2016).

29. WHO. WHO policy brief for the implementation of intermittent preventive treatment of malaria in pregnancy April 2013 (revised January 2014). WHO Department for Maternal, Newborn, Child Adolescent Health (2014).

30. WHO. Intermittent preventive treatment in pregnancy (IPTp) (2015).

31. World Bank Group, UNFPA, World Health Organization, UN Population Division…Trends in Maternal Mortality: 1990 to 2015: 32.

32. World Health Department of Health Statistics and Information System, State of Inequality, Reproductive, Maternal, Newborns and Child Health (2015).