**INTERNATIONAL NURSES DAY 2011**

**ORGANISED BY**

**NATIONAL ASSOCIATION OF NIGERIA NURSES AND MIDWIFE**

**KEYNOTE ADDRESS**

**THEME; CLOSING THE GAP: INCREASING ACCESS AND EQUITY**

**By**

**Dr. (Mrs.) C. O. Agbedia,**

**Department of Nursing Science, Delta State University, Abraka,**

**DELTA STATE**

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**Introduction**

It gives me great pleasure to be part of the International Nurses Day 2011 organized by the National Association of Nigeria Nurses and Midwife with the theme; Closing the Gap: Increasing Access. I am also honored to be invited to deliver this keynote address at this important gathering. I appreciate the executives of National Association of Nigeria Nurses and Midwife and the entire nurses in Nigeria for this invitation. The need to improve access and equity is at the heart of the Millennium Development Goals (MDGs), which were agreed by 192 member states in 2001. UN General Secretary Ban Ki-Moon in his 2010 progress report (UN, 2010), describes the MDGs as representing “human needs and basic rights that every individual around the world should be able to enjoy – freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality”.

The MDGs reflect the need for multi-sectoral approaches in order to improve the health, welfare and well-being of the world’s population. The premise is that conditions in which people live and die are, in turn, shaped by political, social and economic forces. Health related goals include reducing child mortality rates by two-thirds, maternal mortality ratios by three-quarters, and halting and reversing the spread of HIV, tuberculosis and malaria by 2015 A review of the health-related Millennium Development Goals conducted in 2008 (WHO, 2008a) found that while progress was being made in health interventions such as malaria and HIV control and measles immunization (UN, 2010)., significant inequities remained between the wealthy and the poor, between the developed and developing nations, between men and women and between rural and urban. Most of the targets are unlikely to be met by 2015.

The essential link between health and the living environment was recognized in 2005 when the World Health Organization (WHO) established the Commission on the Social Determinants of Health to marshal the evidence of what can be done to promote health equity, and to foster a global movement to achieve it. Nurses and other health professionals have an important role to play in achieving health equity, and developing a strong understanding of how the health sector can act to reduce health inequities is vital. The premise here is that the ability to achieve good health or, conversely, the risk of suffering ill health, is affected by socio-economic status, geography, labour market participation, education, gender, sexual preference and a host of other elements that impact, both directly or indirectly on one’s ability to achieve and maintain good health.

My assignment is to advance thoughts on the theme of this year international nurses day in an embracing manner with the hope that focused papers will address in-depth ideas on its sub-themes. In the course of this address, attempt would be made to do a brief situational analysis of health status of Nigerians explore the concept of access and equities, explore strategies that the nurse can use to ensure access and equity in the care of the 21st consumer. Suggestions to sustain these strategies are made.

**Concept of Access and Equity**

Two key words in this presentation are Access and Equity

**Access**

**Access as** a concept varies according to context. However, “good access exists when patients can get the right service at the right time in the right place” (Chapman et al., 2004, p. 374). Key elements of access include

* availability, utilization (use of available services by the population),
* relevance (services provided reflecting the service needs and preferences of the population groups), effectiveness (whether the desired treatment or service outcomes is achieved), and
* Equity, which refers to differences in the access across different groups, as discussed later in this chapter (Chapman et al., 2004).

**Barriers to access can include:**

• Lack of capacity and availability (shortages of infrastructure or staff so that a service can’t be provided, or lack of services at the place or time they are needed).

• Cost. Full or partial payment for health services remains a significant barrier to the poor.

• Language and culture. failure to cater for different cultural norms can adversely impact on the willingness of people to seek help as well as the effectiveness of treatment.

• Lack of knowledge and information. Access includes access to information about one’s own health, about preventative strategies and approaches, and about the kinds of services that are available.

• Mobility and migration.

• Employment.

• Staff sensitivity and preparedness. Professional standards and ethics require nurses and other health professionals to provide services competently and professionally, and to treat patients with respect and sensitivity. Effective training and management should support nurses in maintaining these standards.

• Discrimination. Despite the commitment of health services and professionals to deliver effective health care, instances of discrimination on the basis of gender, race, sexual preference or socio-economic status continue to exist. .

**Equity**

Equity is often associated with the concepts of fairness and justice. Equity implies an approach that gives more to those who have little, and thus less to those who have much. Equity, thus infers fairness in the way that resources and burdens are distributed across the population, and reducing inequities in that distribution. “An equity approach stands in contrast to a ‘basic needs approach’ or ‘poverty approach’ which focuses on the poor and the disempowered without relating their condition to the rich and the powerful.

 At the centre of the discussion of access and equity is allocation of fair shares to the extent that a basic level of services is available to **all persons** and are able to benefit from it. The question then is how to ensure allocation of fair shares. Osterle (2002) articulated a framework for achieving equity. This includes;

* **WHAT is to be shared (e.g. resources, burdens);**
* **Among WHOM (the recipients); and**
* **HOW (the principles)” (Osterle, 2002, p. 59)**

**Achieving equity in regard to “what”**

Thisinfers defining a minimum set of services or level of resources that it is reasonable and acceptable for persons to have access to. This may also involve defining the particular quality standards or expectations, the level of satisfaction, the level of involvement in decision making, or empowerment

**Achieving equity in regard to the “whom”**

This implies that all persons should receive an equal share, but in realities some people may be excluded from these services through social circumstance, geographical location or other factors. The ability to achieve good health or, conversely, the risk of suffering ill health, is affected by socio-economic status, geography, labour market participation, education, gender, sexual preference and a host of other elements that impact, both directly or indirectly on one’s ability to achieve and maintain good health.

**Achieving equity in regard to the “how”**

Central to this is the extent that the amount of resources allocated should in some way reflect the “need” of the poeple, so that “if the needs of A and B are unequal, they should receive an unequal amount of treatment or support. However “need” is a relative term in itself, and can be measured in different ways, such as mortality, morbidity or quality of life. This “positive discrimination” (Ministry of Health and Social Policy of Spain, 2010) or favouring of specific groups, who have been historically discriminated against in programmes or policies, is seen as a means by which health care systems can seek to achieve better equity in outcomes.

**SITUATIONAL ANALYSIS OF HEALTH STATUS IN NIGERIA**

The status of health of any nation is a strong indication of human development and also serves as indicator. According to World Health Organisation (2000), overall health system performance records ranked Nigeria as 187th out of 191 countries thus making the country to rank among the worst. The Federal Republic of Nigeria has an estimated population of 150 million (National Planning Commission, 2008) of which 49% are females and 51% as females. The country operates a three-tiered governance structure - Federal Government, 36 semi-autonomous State Governments, and 774 Local Governments with wide regional, socio-cultural, economic and geographical diversities existing across the country ( Federal Ministry of Health, 2005).

The life expectancy at birth is 49 years while disability adjusted life expectancy at birth is 38.3 years, preventable diseases still exact their toll of health of Nigerian remaining the major causes of morbidity and mortality rate. Infant mortality rate is 75 per 1000 live births, child mortality rate 88 per 1000 live births, under 5 mortality rate 157 per 1000 live births (FMOH, 2005). These facts contribute a disproportionate 10% to the global burden of maternal and infant mortality (FMOH, 2008). The National Demographic Health Survey (National Population Commission, 2008) health system performance indicators documents an immunization coverage of 23%; 6% of under-fives sleep under insecticides treated nets (ITNs), only a third of children with fever are appropriately treated with anti-malarial and less than half of deliveries are conducted by skilled personnel. Wide variations exist in these indicators in different geographical zones, states, rural/urban location.

In Nigeria, the total per capita health expenditure is estimated at about $10 with about 70% out-of-pocket expenditure (OOPE). It is estimated that more than half of Nigerian population (54.4% or 10 million) live in poverty with 70.8% of this living below the poverty line of less than $1 per day (United Nations Development Programme, 2002). The urban poverty incidence being 40.1% compared with rural poverty incidence of 60.6% (National Bureau of Statistics, 2005).

Healthcare delivery system in Nigeria is in two compartments, the government and the private sectors. In 2005, the Federal Ministry of Health estimated a total of 23,640 healthcare facilities in Nigeria of which 85.5% are primary health care facilities, 14% secondary and 0.2% tertiary. The private hospitals are run on the amount of fees paid by clients with no subsidy from government; rather they have financial obligations for the government in terms of taxation, registration of businesses, payment for adverts and tenement rates. All these services are indirectly paid by consumers of healthcare in the private sector. The other component of health care delivery consists of institutions controlled by the government at three levels – the Federal, state and local government. The amount of money allocated for the health sector over the years had been inadequate judging from the country’s health indicators.

Healthcare in Nigeria is financed from a mixture of budgetary allocations from the Federal Government, States Ministries and Local Government, private-out-pocket expenditure, external development funding grants and a slow but growing social health insurance contributions. (Table 1)

**Table 1: Sources of Health Financing in Nigeria**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sources** | **1998** | **1999** | **2000** | **2001** | **2002** |
| Federal Government | 9.68 | 9.38 | 10.59 | 17.59 | 12.39 |
| State Government | 3.92 | 3.61 | 6.30 | 7.97 | 7.41 |
| Local Government | 1.32 | 3.63 | 1.89 | 1.67 | 1.80 |
| Firms | 2.74 | 3.51 | 4.67 | 5.72 | 6.39 |
| Donors | 13.08 | 13.85 | 16.22 | 5.57 | 6.14 |
| Household | 69.21 | 66.03 | 60.03 | 61.50 | 65.87 |

*Source: WHO (2005) National Health Accounts*

From the table, it is can be argued that the household is a major source of finance for the health sector and out-of-pocket expenditure which is now 70% (FMOH, 2009) constitutes the major percentage contribution in health care. This means that out of the half population of Nigerians that live below the poverty line and on about $1 per day and many that are barely above need to pay for health services at the first port of call even before care is given. This means that the poor spend a an appreciable amount of their meager income on unpredictable health emergencies and health care services

The fact that out-of-pocket expenditure is about 70% with the household bearing the burden of expenditure than other sources has severe consequences on the quality of care services that are accessible to the populace. The vulnerable, less privileged that constitute the majority of the population will utilize low quality facilities or not utilize any at all. Ethnic minorities and migrants, the unemployed or underemployed, the poor, women, children, the sick and the aged fall into this poverty trap..

Successive Governments have strived to improve the health status of Nigerians, through a series of national development plans and annual budgets, and modest progress is being made The country is largely challenged in achieving the Millennium Development Goals by 2015. With the advent of a new decade, and a new leadership it is hoped that health sector will be repositioned to implement and institute result oriented programmes within the context of the MDG and national targets as enshrined in the National Vision 20:2020, and National Health Plan.

**Nurses Enhancing Access and Equity**

**Professionalism and ethics**

The need to provide services, opportunities and rights to all persons “without distinction of any kind” is enshrined in the Universal Declaration of Human Rights, The International Council of Nurses has the principles of human rights and equity as an integral part of nursing ethics. This is seen in The ICN Code of Ethics for Nurses (2006) which states that

 **“Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.” (ICN, 2006, p. 1).**

Thus, equity and access is assured when;

• The nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual family and community are respected (ICN, 2006, p. 2).

• The nurse shares with society the responsibility for initiating and supporting action to meet the health and social need of the public, in particular those of vulnerable populations (ICN, 2006, p. 2).

• The nurse, acting though the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

**Developing roles and flexibility**

The theme of this workshop this year calls for the development of new roles and flexibility for nurses as an important strategy to improve access to many services. Now is the time for nurses in Nigeria to plan towards establishing, nurse led clinics and services, nurse consultant positions nurse prescribers, and clinical nurse specialists. Increasing the role and deployment of clinical nurse specialists and nurse practitioners has been demonstrated to improve quality care and reduce organizational costs. Chapman, J. L., Zechel, A., Carter, Y. H. & Abbott, S. (2004) conducted a review of strategies employed to improve access to primary care in the UK, and found that nurse-led primary care has been used to “combat poor service access in areas having difficulties recruiting and retaining GPs”, and that nurse-led triage and telephone consultations could save time and improve access without affecting quality of care Introducing appropriate new cadres such as nurse prescriber in New Zealand has been an effective way to reduce costs without adversely affecting patient satisfaction and has been successfully employed in areas of severe nursing workforce shortage.

**Research**

Evidence has shown that disparities arise in the area of research, as well as in other areas of health service delivery. A study by Cohn (2007) analyzing nurse researchers in the area of HIV found that clinical research did not always adequately represent the population in question. For example, in the USA it was found that although black women represented 67% of new AIDS cases in 2005, they were underrepresented in all clinical trials. The author notes that this is not only poor practice in terms of clinical research, but also precludes learning about the political, social and individual factors that influence the spread of the disease. Cohn (2007) argues that nurses, with their experience of direct patient care uniquely positioned to ensure that patients are well informed and that research protocols are developed in a way that ensures proper participation and representation from all population groups.

This implies that the nurse must have skill in accessing and critically analyzing research. However, nursing literature is replete with the fact that nurses do not often use research findings in their clinical practice.. Organizational and structural issue is undoubtedly significant inhibitors to nurses’ involvement in research. The chronic shortage of nurses is militating against evidence-based nurse. Nolan, M., Morgan, L., Currant, M., Clayton, J. & Parker K. (1998) describe a study to identify the perceived barriers to implementing research. Twenty-nine barriers were identified and the top ten are as listed in Table I below.

Table 2 Barrier to implementing research.

|  |
| --- |
| Top Ten Barriers In Percentages |
| Ranking  | UK data | USA data |
|  |  | (%) | (%) |
| 1 | There is insufficient time at work to implement new ideas. | 84 | 72 |
| 2. | Resources are inadequate for implementation | 81 | 68 |
| 3. | The nurse does not feel she has enough authority to change patient care procedures. | 74 | 75 |
| 4. | The statistics are difficult to understand. | 73 | 68 |
| 5. | The research is not easy to read and understand.  | 72 | 54 |
| 6. | Doctors will not cooperate with implementation. | 70 | 71 |
| 7. | The nurse does not have time to read research. | 69 | 67 |
| 8. | Other staffs are not supportive of implementation. | 67 | 71 |
| 9. | The nurse does not know what research is available. | 66 | 76 |
| 10. | The relevant research is not available in one place | 62 | 63 |

 Source (Nolan et al, 1998).

Nursing practice should offer the opportunity and support for nurses to achieve the skills required to provide care that is safe, evidenced-based and meets expected standards. Entering into collaboration with trained researchers in other health fields in action research projects is another essential avenue of ensuring that the novice nurse practitioner becoming directly involved in nursing research..

**Advocacy and Lobbying**

Nurses, over the years, have intuitively seen themselves as patient advocates, as they mediate between patient and community resources, between patient and medical services and between patient and family. Henderson (1966) clearly suggests some notion of advocacy in the nurse’s role, stating that: “the unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health of its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible.” The International Council of Nurses (2006), the code of professional Conduct (UKCC, 1992) and the advisory document “Exercising Accountability” (UKCC, 1989) take the same stance: all clearly expect practitioners to accept a role as advocate on behalf of their patients, thereby ensuring that they have enough information to exercise control over their own healthcare, their legal and moral rights are respected, and healthcare resources adequate to provide an appropriate quality of care. The goal of advocacy is to promote the maximum degree of client self determination given the client’s current and potential status. Thus it can be argued that when a community is able to choose strategies for health based on appropriate information, local resources, accessible support and institutional, organizational and social approval, it can be described as empowered.

Lobbying just like advocacy is a concerted effort to influence policy makers to take certain positions on prospective bills. This could be employed by nurses to improve the health and health related issues, and well being of a community. The nurse advocate should work with the community to promote social change aimed at:

* Preservation of the planet and its resources
* Healthy and safe communities.
* Healthy families.
* Equitable and accessible health care.
* Healthy ageing.
* Overcoming epidemics, and
* Addressing the needs of vulnerable groups; single parents, women, adolescents, children, migrants, the poor, the unemployed, the homeless, the isolated and the ill.

Lobbying and advocacy thus are a key part of nursing’s role in addressing issues such as equity and access, and involve the development of a different skill set and knowledge base.

**Provision of Culturally Attuned Data**

One of the challenges in achieving reduction in maternal death in Nigeria is the paucity of reliable data and statistics on social, demographic economic, health and health services variable. Even when the data are available they are not accessible to the health work force and the general public. This has led to the call for a culturally attuned data. Cultural nursing assessment “refers to a systematic appraisal or examination of individual, groups and communities as to their cultural beliefs, values and practices to determine explicit nursing needs, and the intervention practice within the cultural context of the people evaluated” (Leininger 1998 pp. 85-86). In collecting this data, the nurse is expected to be sensitive to both verbal and non-verbal communication cues from the patient. This often creates problems in a multicultural setting. Nigerians for example generally amplify the volume when talking; therefore a nurse who correlates loudness with anger may misinterpret what should have been a perfectly normal communication pattern.

In collecting culturally attuned data the nurse is interested in the extent to which the client’s beliefs, values, and customs are congruent with a trifold set of standards, Standards of client’s identified culture or ethnic group, Standards of the nurse’s own culture,Standards of the health care facility that serves as the setting for the interaction. if areas of incongruence are identified, the nurse needs to find out if the client’s system is adaptive (beneficial), neutral, or maladaptive (harmful) in relation to possible interventions.

The most important tool is self-examination. Nurses need to critically and continually examine their own beliefs. Only by knowing one’s own cultural beliefs well can one be ready to learn about another culture. Culturally sensitive nursing practice must also include

• Use of interpreter services.

• Recruitment and retention of staff who are members of minority groups.

• Coordinating with traditional healers.

• Culturally competent health promotion.

• Including family and/or community members.

**Continuing Professional Development**

Continuing Professional Development (CPD) programmes in nursing are well known by nurses. The Mandatory Continuing Professional Development Programme (MCPDP) of the Nursing and Midwifery Council of Nigeria is designed for all cadres of nurses and is to be undertaken throughout their professional nursing career. It is a continuous formal learning programme The goals include; exposing nurses to current development as well as new trends in health and nursing care, sharpen the knowledge and skills of nurses and to constantly bring to the fore health issues and conditions that constitute serious health challenges to the individuals, families and communities at large. Each participant is expected to have 90 contact hours which is 6 units of MCPDP every three years.

An area that is often overlooked is the nursing care for the disabled (Brown, M., MacArthur, J., McKechanie, A., Hayes, M. & Fletcher, J., 2010) The authors argued that many nurses have not received sufficient training to enable them to deliver quality care, citing a study of practice nurses which found that only 8% of respondents received training on issues related to learning disabilities. Effective training and skills development is also needed if nurses are to deliver the accessible care which promotes equity and is free of discrimination.

It is also important that managers, including nurse managers, and employers ensure that they equip their employees with information and training appropriate to the needs and preferences of the local community. Actively seeking to recruit staff who are members of local minority groups, and to support those staff in the workplace, is also an important step to both making services more accessible to clients and to ensuring that those clients receive the same quality of care enjoyed by the majority.

**Implication for Stakeholders**

**Federal Government**

**Nursing education**

Funding of nursing education is one of the foremost issues. Within the context of equity, efforts shall be made to ensure appreciable financial allocation to nursing programmes. Against this background the adverse effects which inadequate supply of equipment have on nursing students at all levels can only be imagined. Most students only see and read about certain common equipment in textbooks. Even these textbooks are in the reference sections of the libraries! Some are as old as Methuselah.

There is also acute shortage of nurse educators.There is a dire need to overcome this challenge. The quantity and quality of staff must be adequate for the number of established departments of nursing. There is usually a teacher/student ratio of 1:10 for effective learning. This has to be adhered to in order to produce competent nurses to function in all areas of nursing. Retired but productive staff can be encouraged to serve as adjunct lecturer. The use of retired nurses in the Midwives Service Scheme is a welcome idea; this will go a long way in reducing maternal and infant mortality. Having the appropriate technology infrastructure and up=to=date resources is also critical to successful learning. E-learning should be encouraged to thrive, although there are many things to consider in E-learning as far as the level of development is concerned. Issues like accessibility; affordability and feasibility in the face of epileptic power supply raise concerns.

**Nursing and Midwifery Council of Nigeria and National Association of Nigeria Nurses and Midwives**

Majority of nurses in Nigeria have successfully convinced themselves that their future lay outside politic. By politics they usually mean partisan party politics. But it is possible to participate politically without being partisan. The consequence of this is that nursing leaders remained largely out of contact with any of the major political networks which have so influenced other ‘professional’ groupings in society. The idea of nurses that politics is distasteful must change. Political participation as an individual nurse and a member of an organization is essential as such a time like this

National Association of Nigeria Nurses and Midwives must continually strategies on how nurses’ interests can be articulated. This body must contribute effectively to policy debates not only on how the health system is oriented, structured and managed, but also on broader policy issues which address the social determinants of health. The Nursing and Midwifery Council of Nigeria in collaboration with the National Association of Nigeria Nurses and Midwives must embark on programme evaluation to assess the usefulness of the Basic Community Midwifery Programme on health. Action research on the perception of the graduates on their roles and its challenges these are also needed to ensure adequate utilization of the programme.

Dramatic reform and innovation in nursing is needed to create and sharpen the future of nursing practice. For too long nurse educators and nursing service personnel, although cordial and respectful of each other, have not been fully engaged in collaborating to prepare a workforce that can practice effectively in new healthcare environments. This current challenge demands innovative ideas, creative thinking and action, aimed at bridging the ever widening gap between theory and practice. Nurse educators need to be conversant with current practice in the clinical areas so that they can develop their research areas as well as develop theoretical basis for practice. In such a system, the very nature of "fundamental skills" and customary approaches to planning care are being challenged. Therefore, nursing service personnel must work with lecturers, and students to design innovative nursing systems that meet the needs of the health care delivery system now and in the future.

**Conclusion**

Chairman, distinguished ladies and gentlemen, it is beyond reasonable doubt that the theme of the International Nurses Day 2011 is about excellent nursing care to clients and a move towards focusing upon the poor. However, access and equities in health are not static or inevitable phenomena. They are driven by the interplay of biology, social organization, and health systems. This is cause for optimism. Things can change and do change. I hope that this discussion will stimulate you to take a fresh look at the problems of access and equities in health vis- a-vis the diagram below, and in so doing contributes to well being of the populace..

WELL BEING

Decreased

Mortality

Control over

Fertility

Healthy/

Sustainable

Environment

Decreased

Morbidity

Increased

Nutritional

status

Improved

Women’s lives

Increased

Income/

Livelihood

Security

Thank you for listening; you have been a wonderful audience

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**Increasing access through nurse prescribing**

In Sweden district nurses with additional training have prescriptive authority. The Swedish Medical Products Agency created a list of products which nurses can prescribe. This list has over 230 brands of medications that qualified community nurses can prescribe for 60 conditions. Evaluation of nurse prescribing showed positive results in terms of improving access for patients, the elderly and disabled people.

**Implications to Nursing Education and Practice**

The following are proffered as strategies for ensuring effective use of nursing skills in nursing education and practice.

**Strategy 1**

**MDG 4: Reduce child mortality**

• Global prevalence of underweight children had declined from 31% to 26% since 1990 but progress is slow and no progress has been made in Western Asia and remains at 46% is Southern Asia, where more than 25% of infants are underweight at birth.. (UN, 2010, p. 13)

• Sub-Saharan Africa now accounts for around half of the 8.8 million deaths that occur among children under five in 2008 (UN, 2010, p. 27)

**MDG 5: Improve maternal health**

• More than half of the 500 000 women that died of maternity related causes in 2005 were in sub-Saharan Africa, and one third in South Asia. Maternal mortality ratios in sub-Saharan Africa are 920 per 100 000 live births compared with 8 per 100 000 live births in industrialised countries (WHO, 2008a)

**MDG 6: Combat HIV/AIDS, malaria and other diseases**

• Despite dramatic increases in antiretroviral treatment in low-and middle-income countries, about a quarter of those who need the treatment in sub-Saharan Africa have no access to it. Coverage for children is even lower, at 15% (WHO, 2008a).

• It is estimated that 243 million cases of malaria in 2008 led to 863,000 deaths. 89% of these occurred in Africa (UN, 2010, p. 46).

• In low and middle income countries, the proportion of HIV-positive pregnant women receiving antiretroviral treatment for prevention of mother-to-child transmission of HIV was as low as 11%.

• Only one third of children under five with fever in Africa receive any anti-malarial treatment (WHO, 2008a). WHO reported that services than can be delivered by outreach such as immunisation have shown encouraging results, “those interventions requiring a functional health system … are having less impact” (WHO, 2008a, p. 2).

**Key constraints identified in achieving these goals include**:

• Shortages of well-trained health workers;

• Insufficient responses by governments to the health needs of their populations, for a variety of reasons, in “fragile states”; and

• The need for greater cooperation between sectors: private, public, voluntary, and community and faith-based.

This finding highlights the crucial role to be played by health systems and health providers in promoting health, preventing avoidable disease, and addressing morbidity in key areas in achieving the MDG goals, and realising the lives saved and illnesses prevented that those goals represent.

 **“Disparity is a shocking reality we cannot hide from. This is a global injustice. It is a travesty of human rights on a global scale” Nelson Mandela, 2003 (cited in McCoy, 2003)**

The right to health, and the right for an equal opportunity for health, is part of this. It is also important to recognise that health is not merely a commodity produced by health services. Health is socially determined, as well as being influenced by genetics and environment. The ability to achieve good health or, conversely, the risk of suffering ill health, is affected by socio-economic status, geography, labour market participation, education, gender, sexual preference and a host of other elements that impact, both directly or indirectly on one’s ability to achieve and maintain good health.

 The commitment In 2001, of the international community .to the Millennium Development Goals (MDGs) represented a determination to make significant improvements in the health status of the world’s population as the burden of illness and disease was not equally distributed. As noted by McCoy (2003, p. 8)

“The notion of equal opportunities to be healthy is also grounded in the human rights concept of non-discrimination and the need for governments (or the organised representation of society) to take the necessary measures to eliminate the unfair health consequences of social disparities.

…Judging whether a process is equitable depends on the definition of what society accepts as an equal right of all.

Some emphasizes inequalities in health outcomes; others emphasize the opportunities for good health outcomes.” The Pan American Health Organisation (PAHO) has also recognised that the concept of justice is important, and that “all inequities are the product of unjust inequalities”. It states that while “just and unjust are subject to various interpretations. In the context of health, one of the more accepted definitions of just refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay.” (PAHO, 1999). This enshrines the notion of universal health care and access as part of a just health system.

#### ENCOURAGING SAFE CULTURAL PRACTICES

Nigeria has about 250 ethnic groups and three major religions. These groups have their norms, values and cultural practices. These cultural practices have negative or positive influence on the health of the women and children who are the most vulnerable group. The nurse must discourage negative practices that may lead to problems during pregnancy, labour and after delivery. Such include:

* Female genital cutting (FGC). A recent national survey says that the prevalence of FCG in Nigeria is 19%. It is as low as 0.4% in the North west, 1.3% in the North east, 9.6% in the North Central, 34.7% in south-south, 40.8% in South east and as high as 60.7% in the South West (NDHS 2003)
* Early Marriage.
* Harmful delivery/postnatal practices
* Widowhood practices
* Tribal marks and body scarification
* Wife beating
* Child abuse

In encouraging healthy cultural practices the community midwives must first clarify her values to prevent ethnocentrism. In collaboration with other health professionals, intensive awareness campaign against these practices must be mounted. She must be involved in advocacy at policy level and legislative level against FGC. With her knowledge and skill she can also initiate the production and distribution of health education leaflets on safe cultural practices.

#### Provision of safe motherhood

Safe motherhood is defined as a concerted, collective effort by pregnant women, herself, her immediate and extended family members, her community and all health personnel at the primary, secondary and tertiary levels to ensure safety of a pregnant woman and her baby during pregnancy, delivery and after delivery, (WHO 2005). Safe motherhood is one of the WHO global strategy aim at reducing maternal morbidity by 50% in 2000. In providing safe motherhood the community midwives must center her care on the pillars of safe motherhood, which are:

* Family planning

Focused antennal care

* Clear safe delivery
* Newborn care
* Postnatal care
* Post abortion care
* Emergency Obstetrics care
* Treatment of STIs / HIV/AIDS

NDHS (2003) and WHO (1999) address the three delays to effective, timely utilization of maternal care services. These are: delay in seeking appropriate health care by women, delay in accessing health care facility and delay in receiving care in health facility Since safe motherhood programme involves multiple sectors (education, Health, human right, transport) the community midwife in collaboration with other health professionals must ensure adequate implementation of the mother- baby package. . The usefulness of the package is that it outlines what can be done to prevent and manage major obstetric complications in the community, at the health center and at the hospital. The danger of this is that the package could not be used as a cookbook, this should not be so, in that midwifery practice is not straight jacket but depends on a lot of factors.

**ACTIVE INVOLVEMENT IN BIRTH PREPAREDNESS AND COMPLICATION READINESS**

Birth preparedness and complication is a concept in health care delivery aimed at averting the delays of pregnant women in seeking, reaching or receiving care through advance preparation and rapid action. Birth preparedness and complication readiness Myles (2003) argues is a shared responsibility between individuals, the families, the communities, and health facility. In these regards the role of the community midwife should include:

* Creation of an enabling environment that supports the survival of the pregnant and the new born.
* Active involvement of the husband in the care – financially, physically and emotionally.
* Community mobilization towards women empowerment and the education of the girl child.
* Identifying those individuals that will stay with the pregnant woman in the hospital.
* Encouraging women to save money towards delivery (opening a new account).
* Buying and storing materials needed during after delivery/birth.
* Taking the pregnant women through causes, sign and symptoms of various complications before, during and after delivery and how to call for help or when and how to get to the hospital before the complication become serious.
* Comprehensive history taking and examinations.
* Laboratory test for STIs/HIV.
* Health talk on nutrition and cleaniness

As seen in research literature health sector reform is strongly driven by donors models of reform. In this context the donors’ objectives explicitly include targeting public sector and resources to where they will most reduce the disease burden, and filling gaps in the primary and preventative care system for the poor in order to do this. Improving the allocation of health care resources and improving equity are both highly desirable objectives, but this approach has been flawed as it is deliberately unequalizing in health system terms. This is because the intentions at face value-have obscured both the mixed objectives being pursued in practice, and the problematic **State Government and Local Government**

In other to increase women’s access to health care, government and health systems need to establish management guidelines that specify required facilities and equipment for the provision of high quality nursing and midwifery practice including referral and supervision protocols. This lack of basic infrastructure as in time past have led to the drift of health workers from rural areas to urban centers.

 Public and private sector health care systems should identify and remove policies and practices that in inhibit women’s access to care.

implications of context and institutional process for the outcomes of the reforms in the health sector