



# Identification and Review of Common Challenges Militating against the Attainment of Health-related Millennium Development Goals in Rural Nigeria

H. Wankasi<sup>1\*</sup>

<sup>1</sup>Department of Public Health, Bayelsa State College of Health Technology, Nigeria.

## Author's contribution

The sole author designed, analyzed and interpreted and prepared the manuscript.

## Article Information

DOI: 10.9734/BJAST/2015/16885

### Editors:

(1) Lesley Diack, School of Pharmacy and Life Sciences, Robert Gordon University, UK.

### Reviewers:

- (1) Audu Onyemocho, Department of Epidemiology and Community Health, Benue State University, Nigeria.  
(2) Anonymous, Nigeria.  
(3) Emmanuel N. Anyika, Department of Clinical Pharmacy & Biopharmacy, University of Lagos, Nigeria.  
Complete Peer review History: <http://sciencedomain.org/review-history/10118>

Review Article

Received 17<sup>th</sup> February 2015

Accepted 1<sup>st</sup> June 2015

Published 8<sup>th</sup> July 2015

## ABSTRACT

**Aim:** To ascertain common challenges militating against the attainment of the health related Millennium Development Goals in 2015 in Brass Local Government Area of Bayelsa State and to make policy recommendations.

**Methods:** A systematic qualitative review of related studies aimed at identifying common challenges facing the implementation and actualization of health related Millennium Development Goals was carried out through electronic database, books, and primary data from relevant institutions in the State. Purposeful sampling was done due to the peculiarity of the subject matter. Data were selected and reviewed from 2000-2014, except few included that dated back were relevant to this study. From the search, eighty [80] materials were accessed, but fifty [50] were selected for the review based on pertinent. A thematic analysis was done. The documents accessed were read through, cod-able areas were highlighted, extracted and collated into themes in a coding template. After re-grouping, the units of analysis were identified.

**Findings:** Six outstanding issues were seen as factors militating against the actualization of the health related millennium development goals as viz; leadership 33%, finance 16%, corruption 10%, crisis 6%, man-power, 8% and inaccessibility 6% amounting to 79% of the eleven identified themes. Out of these six, due to word limit, four are discussed.

\*Corresponding author: E-mail: [wankasihelen@yahoo.co.uk](mailto:wankasihelen@yahoo.co.uk);

**Conclusion:** The aim of this article was to elicit common challenges facing the implementation process. 11 were identified, out of that number, 6 were selected as they were peculiar to the setting under review and 4 were discussed due to word limit. What seemingly militate against the implementation in the area under review are leadership and its related variables.

*Keywords: Impediments; attainment; millennium development goals; rural; Nigeria.*

## 1. INTRODUCTION

Experience shows, implementation of well-meaning health initiatives are often met with actual or potential challenges in Brass Local Government Area (LGA) of Bayelsa State regardless of who or what is involved, of which the MDGs are not exception [1]. Rarely, these challenges are promptly identified at the onset [planning stage], but do manifest in the course of implementation or even at the tail end of the programme. Irrespective of when these challenges present, the onus lies on the implementing agency or government institution to embark on periodic identification of issues that affect the programme to enable stakeholders proffer suitable solutions to ensure positive programme outcome and also ensure the success of future health programmes.

As the 2015 dead line draws close, gladiators find it imperative to review some of the MDGs programmes with the sole aim of identifying factors that stand as barrier to the process in certain areas. The rationale therefore for this study, is to enlighten policy makers to focus on such rural settings with special attention to the difficulties pose on the process, so as to take adequate precaution while embarking on subsequent programme. Several articles and gray studies identified impediments to the realization of the MDGs in 2015 target in other settings [2,3], but no review known specifically in respect to challenges faced by various State's rural chapter. The tendency to rely on general challenges affecting the process without due consideration to the impediments affecting the different rural setting[s] is viewed as a significant gap in research.

Irrespective of the fact that, the Deputy Director UN system was quoted for lauding Nigeria of her impressive performance, there are significant challenges [4]. However, another author argued and corroborate that the successes achieved vary from state to state and rural area to rural area even in same region [4,5]. Consequently, this paper feels that gap by unravelling the

barriers that stand against implementation and actualization of the 2015 target in the setting in question. This article elicits common challenges confronting the effective implementation and actualization of health related Millennium Development Goals (MDGs). It also earmarks some contributions aimed to facilitate the attainment of MDGs so as to enhance subsequent programme implementation and sustainability. Regardless of the fifteen year span prearranged for the implementation, following the MDGs' declaration way back in 2000 [6a,6b], the implementation of these three health-related targets intend to benefit poor Member Countries are been confronted with some seeming challenges everywhere [7].

## 2. SOME HEALTH RELATED MDG PROGRAMMES

Some writers alleged, while others assert in the 'performance appraisal of Nigeria's fourteenth year's journey to achieving the set MDGs as mixed, given the progress towards these health related MDG programmes have been below average and less satisfactory [2], [7]. Below are highlights of level of achievement of some health related MDG programmes by [3].

Goal 4: aimed at reducing child mortality; record shows average progress in under-five mortality rate from 301 deaths per 1,000 live births to 201 deaths per 1,000 live births. It also shows slight increased proportion of children immunized against measles from 31.4% to 41.1% and infant mortality dropped from 100 per 1,000 births to 85 deaths as at in 2008 survey [3]. More needs to be done to actualize the intended reduction rate in child mortality.

As regards goal 5: aimed at improving maternal health:- success in this goal has been slow. However, the maternal mortality rate dropped from 800 deaths per 100,000 birth in 2003 to 545 deaths per 100,000 birth in 2008, while there was only 4% improvement in reproductive health following attaching myths to the use of

contraceptives [3]. This area too still needs more attention to improve the maternal health.

Lastly, goal 6: aimed at combating HIV/AIDS, malaria, and other diseases;- generally this goal recorded average progress as evidenced in drop of prevalence of HIV/AIDS to 4% and amongst pregnant women aged 15-24 years to 4.2% in 2008 [3]. Another indicator is the increased proportion of the population accessing antiretroviral drugs increased to 34.4% [3]. The percentage of children sleeping under insecticide-treated mosquito net rose from 2.2% in 2003 to 5.5% in 2008. [3]. Despite the rise in the use of the nets, malaria infection rate remains steady and has accounted for average of 300,000 deaths each year [3]. Due to the untiring efforts of philanthropic organizations such as Rotary International, considerable progress is being made in polio eradication [3]. However, the progress made between 2008 and the present day is quite insignificant [2]. In order words, there are issues at stake that need to be addressed unequivocally to make progress.

In addition to the aforementioned health programmes, the State's health related MDGs covers other areas such as portable water supply and environmental sanitation in the rural areas as in Appendix in recent years some housing projects in primary care Centres and primary care practitioners training institutions. Concerted efforts are made to ensure the achievement of these goals. Most communities especially the rural localities in the State have benefitted and still to benefit from the various programmes and projects [8].

### 3. METHODOLOGY

This qualitative review covers both primary and secondary data [mixed method] from 2000-2014, except four of the articles included that dated. The primary data was through open-ended semi-structured exploratory guide with relevant stakeholders in Brass Local Government Area (LGA) of Bayelsa State. The LGA has a total area of 1,404km<sup>2</sup> [542sqm] with a population of 185,049 as at 2006 census [9]. A coastline of approximately 90km located at the Bight of Bonny by the Edumanom National Forest [9].

Due to the specialized nature of the study the later included anecdotal discussions, write ups from wide range of sources through critical database search, from books, journal articles, gray literatures and the Open lectures organised by State Ministry of Health on related concepts

were included to elicit challenges. Some offline, while others online for instance from Organization for Economic Cooperation and Development OECD site, from IDB, recorded online interview session held by stakeholders from the Presidency on MDGs was recorded with android phone and was transcribed. Others are US legal definitions websites-1, Parliamentary briefing published in This Day -1and the PM News papers 2, Nigeria's MDGs' score card 1, and textbooks. Eighty [80] articles were accessed, out of these fifty [50] were selected due to their relevance to the theme of discussion.

Given, the objective of the study is to draw out challenges, a purposeful sampling was employed, as those eligible were stakeholders in the MDGs' course for at least the last two years knowing they have adequate knowledge on the subject matter Units head intimated and anonymity maintained [10]. Similarly the secondary materials were carefully selected to ensure the materials had bearing with the subject under review [11].

### 4. ANALYSIS

#### 4.1 Four Step thematic analysis [12],[13],[14]

This study adopts six, but compressed to four successive steps thematic analysis [12]. To make sense of the articles, the data were organized, read through repeatedly so as to be familiar with the idea in the data and noting down salient areas from audio tape as in step 1 below. A coding template was created as seen in Appendix-2.

Then step 2 was mainly a systematic collating of the code-able features to generate the initial codes in a separate column. One can figure out similar words and phrases from the extracted texts.

In step 3 the generated and extracted similar words and phrases were coloured for easy identification and were separated. Then these coloured phrases that were separated were re-grouped and the frequently emerging themes were categorized and the percentage at which each theme appeared was noted.

Then in step 4 the generated and named themes were described in the final analyses. The themes named described were based on the frequency of occurrence and the percentage of each theme.

**Table 1a.-c.**

<b>Phase</b>	<b>Description of the process</b>
1 Familiarized with the data audio tape and noted	Reading and re-reading the materials as well as listening to the down Initial ideas
<b>Phase</b>	<b>Description of the process</b>
2 Initial codes generated	systematically collating the code-able features of the data
<b>Phase</b>	<b>Description of the process</b>
3 Searching for themes	Collating code into themes and generated names for each theme
<b>Phase</b>	<b>Description of the process</b>
4 Producing the report	Final analysis of selected themes

In a nut shell the entire analysis process was organisation, reduction, categorization or development of themes and description of the developed themes [12]. Before the description segment of the analysis, a second reviewer crosschecked to determine consistency of the themes [12].

In line with phenomenological epistemology view [13,14], this study seeks to understand experiences of MDGs` policy makers, programme implementers and understand process challenges. Its strength lies on its potentials for building on previous articles and making qualitative contributions [15].

See Table 3 Step 3 for reduced/extracted data to development of themes in groups as in the appendices. The data was re- grouped with colours for easy identification of themes. Articles bearing similar themes were separated and grouped based on spotted themes from each.

**5. FINDINGS AND DISCUSSION**

Sequel to the above groupings, it was apparent eleven [11] major issues identified that seemingly confront the implementation and the realization of health-related MDGs in 2015 and these outstanding issues serve as units of discussions. The breakdown is thus; Out of the 50 articles, [33%] attribute leadership issues as impediment, financial issues [16%], corruption [10%], crisis [6%], policy issues [8%], man power, issues also have [8%]. Others are partnership/ cooperation [6%], awareness issues [4%], socio economic, religious and political atmosphere had, [2%] inaccessibility of facilities/drugs [6%] and discrimination had [2%] as inimical to the

realization of health related MDGs in Brass LGA in 2015. These selected six themes amount to 79% of the initial eleven identified themes.

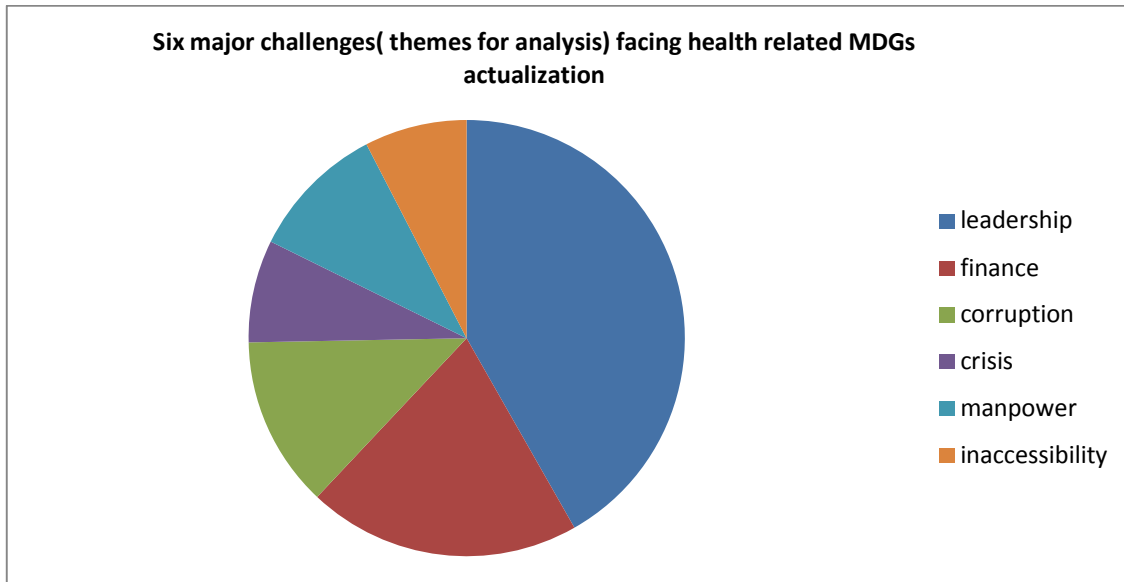
For the purpose of word limit, four of the themes, Leadership, corruption, crisis and inaccessibility that are typical of the rural area under review are discussed, given the area is in the heart of Niger Delta and it is characterized by creeks, sea pirates, significant military presence and far away from the capital city, so the area needs these services more than any setting one can imagine. However, this does not render the rest themes inconsequential. Fig. 1

**5.1 Leadership**

*“,,,,,,,,,,,,,,,,,,,,,because some officials take the control of the country resources” “Many governments lack credible and resource backed strategies for the prevention, treatment, and control of communicable diseases.” [5].*

*“Too little effort is devoted to surveillance, monitoring and evaluation” [5].*

Evidently, as shown from these quotes, leadership stands a very strong impediment in implementation and actualization of health related MDGs. About 33% of the materials available pointed at least to an issue that relate to leadership actions or inactions towards the implementation. What is leadership and what role can a leader play in this context? Literarily, leader is described as one who has the capacity to lead a group of people [16]. Whereas, leadership is an act of influencing others to carry out an assigned task [16] In the light of the above definitions, the leaders [be it political, community



**Fig. 1. Six major challenges (themes for analysis) facing health related MDGs actualization**

or any other leader] have the mandate to influence others irrespective of the level in order to effectively execute the health related MDG programmes. Again, the leaders have power to ensure that efforts are directed on special portions of the task [17]. Meaning, the leader, on assumption of office has an indispensable role in order to successfully harness the efforts of all members of the team and ensure the objective of the UN is realized.

Viewing leadership as a leading challenge that militates the actualization of MDGs in 2015, implies, there are all round leadership lapses in the implementation, including the leaders hijacking the country's resources. Again they are guilty of politicizing these health related programme's contracts, by awarding them to suite their yearnings and aspirations to the detriment of the intended beneficiaries. The instance below gives an evidence of some of our leaders perpetrated antecedence that limit smooth implementation of the programmes as thus;

*"Some contractors called to execute health related MDG jobs do not necessarily qualify in the bidding process, but were merely called to serve as part of efforts to compensate political friends and allies. Such contracts more often than not are abandoned. Again, there is the atmosphere of culture of impunity amongst these crop of contractors" [10]*

This example gives a clue that, some implementers abandon projects with 'impunity' given, the leaders mandated to ensure the effective implementation of the project are found wanting. This could be deduced that, it was perpetrated with the leader's consent and as a consequent of the leader's involvement, the leaders develop 'cold fit' when it comes to imposition of sanction on defaulters and enforcement of laws guiding the process. Again, the above statement could also mean, some leaders do award contract to themselves, but merely sublet to others seen at the site and at other times, the sub contractors are to play a supervisory role. As such, the leader ignores programme executed below standard or abandoned. It also implies that, those at the helm of affairs lack the skills or the technical expertise to execute health related MDGs projects and are not willing to partner with others who have the requisite knowledge, skills and wherewithal. Little wonder in one of the articles the writer commented.

*"There is minimal public private partnership in terms of resources [human and material] allocation into health programmes implementation" "There is a huge challenge for our Group requiring intensifying efforts to raise funds, leveraging partnerships with development partners and the private sector and perhaps,,,,,,," [10].*

“Synergy or its lack of faith amongst the various tiers of government” [18]

The above comment also meant, less effort is geared towards partnership. This also probably explains why others commented below;

*“Africa is her own enemy in terms of the health related MDGs. With the kind of leadership we see in Africa- the rate of corruption and waiting for other people to chart the course of our wellbeing is our downfall,”* [18].

He further buttressed his point of seeing leadership as a challenge to the successful implementation of health related MDGs in 2015 by continuing with the statement below;

*“Bad leadership with no focus for the people,,,,,,,,, self fish”* 19].

*“Many governments lack credible and resource backed strategies for the prevention, treatment and control of communicable diseases”* [19].

*“Too little effort is devoted to surveillance, monitoring, evaluation and learning the lessons of such exercises”* [5].

However, from all indications, not all leadership issues that pose challenge to the MDG course. Some instances proved that, as synonymous with Africa, incessant power changes have negative impact on the leaders` performance, given-, leaders are forced to quit offices unceremoniously without previous warning [19]. As a result, ongoing programmes embarked upon by previous administrations are often time ignored as soon as the leaders who initiate the programme leaves the office. The fact that the incoming leader rather than to build on the existing programmes, would want things done his own way, abandons the ongoing programmes of his predecessor. The statement below, attests to this assertion.

*“Lastly, political instability and programme discontinuity results to frequent changes in the leadership. The successive governments oftentimes formulate its new policies and programmes rather than to continue and build upon existing ones embarked upon by their predecessors. In serious cases, the old programmes are abandoned for the new ones. Although, the state have only encountered few cases from the previous administration”* [19].

In linking leadership to the remaining themes selected for this discussion. If a leader acts contrary to the responsibility vested on him, he might influence members of the team [donors, implementers, policy makers and beneficiaries] contrarily towards the intended goal. The leader`s influence could negatively impact in a way that leadership will pose a huge challenge to the implementation of health programme significantly as opined by many.

Again, other variables identified are all issues effective leadership could handle. Performing and incorruptible leader hardly perpetrate or encourage any form of corrupt practices as stated. Rather he could influence other team players positively to advocate for fund, promote peaceful co-existence amongst warring factions, solicit for government intervention to provide drugs and other infrastructures in health facilities and work out modalities on how the difficult terrain issue be addressed. The leader could also encourage manpower sourcing, work force development and building the capacity of implementers to address the issue of man power lack. Most importantly the leader could embark on research programmes that are capable of improving and update standards.

In same vein, the leader can motivate his workforce for effective health related MDGs programme implementation and realization [20]. Motivating the workforce is by creating the enabling environment to influence response and to influence government policies that will mitigate the impact of these ailments [childhood diseases and maternal problems] [20].

Motivation entails promoting good social network, support and reciprocate good gesture, support team spirit, up skill team through training, appreciation/recognition, show them ideals, coach them one on one, give them leverage, promote workplace freedom as was employed by management experts, so as to encourage participatory management, openness that will promote effective health related programme implementation to meet the 2015 target and beyond [20].

## 5.2 Corruption

Another theme identified that seemingly limit the actualization of the MDGs in 2015 in the state is corruption. At least 10% of the articles attest to this factor.

*"You would see that one of the major problems in our country today is corruption and mismanagement of public resources"* [2].

"Basically, it ends with corruption and greed not only by the ruling class, but also the business society and individuals" [2].

A publication on the costs and benefits of corruption in developing countries, views corruption as a phenomenon that public good uses for private gain by both public and private sectors [20]. He re-emphasized further that, the phenomenon is predominant in developing countries in which the rural setting under review is part. This statement gives credence to the assertion made at the Joint Parliamentary committee briefing [2], which states that:

*"Nigeria may not achieve the health related MDGs in 2015 due to corruption and other issues"* [2].

Africa is her own enemy in terms of the MDG's. With the kind of leadership we see in Africa-the rate of corruption and ,,,,,,,,,,,,,, is our downfall. [20].

Bearing in mind Nigeria is a nation with 36 States and a federal capital territory within the African continent- a developing country. The statement above implies that, like any other region within the Sub-Sahara, corruption and its attendant consequences obviously thrive and affect implementation of the MDGs in the light of the above statement[s] quoted. Some writers opined that corruption is perpetrated in rural areas in several forms as thus;

It is a good practice to give aid, but in the face of corruption giving aid is describe as "wastes" by transparency international, because, there are perceptible overpayments of goods and services by stakeholders [21], yet, proposed beneficiaries [women and children] are not affected and resources are scarce despite acclaimed funding of such programmes. Implementation processes are still questionable. Notable of such overpayments they claimed are on health care facilities, drugs and work force [22].

Regrettably, often, these facilities and drugs are substandard as quoted below;

*"With corruption you see unqualified public servants" "the slow pace on achieving this goal is as a result of poor medical facilities and half-*

*baked doctors and nurses"* [10] and inadequate labour recruited and other essentials such as transportations are not provided as stated;

*"To combat HIV/AIDS, malaria, and other diseases,,,,,, The proportion of the population accessing antiretroviral drugs increased to 34.% though still very costly, basically for the elite"* [3].

Most pertinent, funds meant for remuneration of implementers are slashed and left with little, monies meant for programme are used illicitly for personal gain, in a way that materials become insufficient and in some instances, find it even difficult getting to intended destinations [22] From all indications, corruption in the region escalates the poverty level, even if there are oil installations/companies operating [22]. Not only that, "it creates social and economic disparity" which characterizes the environment. The statement below corroborates this assertion.

*"We've had increase in unemployment and this definitely would directly affect abilities of families to have decent standard of living"* [2].

This shows the state has corrupt politicians who monopolize and misappropriate public funds, which created extensive poverty and sickness especially at the rural settlements that need health related MDGs programme intervention. Little wonder, still a writer added his voice by saying.

*"Achieving these three goals is a mirage,,,,,,," "Another biggest problems and why we have not been able to achieve as much as we should have in the MDGs is the corruption and leakage in the system. A corrupt system remains a big drain on our natural resources and a lot of that are traceable to lack of enforcement of law and order"* [2].

However, some experts identified benefits of corruption as an act that can facilitate programme implementation by having what you have paid for in a very short time without difficulty [22]. But, at this instance, there is no benefit of corruption recorded on health related MDGs implementation. Rather what is apparent is backwardness, abandoned and half way completed or poorly completed structures in numerous communities.

### 5.3 Crisis

A psychology expert, while giving her different definitions of crisis, describes crisis as an

unstable situation in political, socio-economic or military affair that causes abrupt change and impedes the course of a given place [23]. According to her, the change of course, causes obstacles to life goals as it results in hopelessness, sadness, confusion, panic and disorganisation [23,24]. These conditions probably occur in crisis for the fact that, those affected sometimes develop what is referred to as tunnel vision meaning inability to see options and possibilities [24].

Incessant crisis in the Niger Delta area is a bizarre phenomenon that has created huge negative impact on its residence (s) for over a decade [25]. Which in this context, have stood as an obstacle to the inhabitant's health goals [MDGs] actualization in 2015. It is known fact that, the rural Brass LGA under review, which is at the heart of Niger Delta, these crisis metamorphosed from minor inter and intra communal conflicts to region wide resource control struggle even before the wake of MDGs. However, the struggle was not targeted at individuals, but at multi- national oil companies and the Federal government that these companies collaborate with in their oil exploration activities [25].

Although this struggle for resource control started long ago, it resurfaced in recent times (2004) and has taken different dimensions, which range from vandalization of government owned facilities, insurgency, piracy that results in insecurity to its inhabitants to disruption of well-meaning initiatives as health related MDGs. This affirmation is stated below;

“Rather than getting involved as partners so as to take ownership of the provision, they rather sabotage the job by way of vandalizing the water boreholes installed at the various health centres” [20].

“Another challenge we face while rendering these services in these areas in conflict is coming in contact with thieves (sea pirate). In such circumstance, all we had on the boat were destroyed by the miscreants”. [20].

From the second paragraph, it is obvious, there is apparent fear and discouragement on the part of implementers in embarking on these services in the area. Strangers are often time kidnapped for ransom and the essential materials [vaccines, mosquito nets and health care facilities are destroyed and programmes are disrupted. Like Indonesia, the protracted crisis have led to a

substantial reduction in health services utilization, given, individuals living in communities that need these services have fled their home, leaving their aged and handicapped. [25], who in the real sense are unable to carry themselves to the health facilities for health care without the assistance of their capable children, caregivers or even grand -children.

Some of the communities, these militants numbering up to 300 able bodied youths at the prime of their life stationed in these areas as insurgents, have lost over hundreds of youths with a casualty figure of not less than 500 persons [25]. However, the crisis is not limited to only the rural area in question, but it is one of their main concentration camps. For now insurgency cuts across every region in world. What makes this area unique is, the resurgence at every little provocation. Presently the North-Eastern part of the country has the Boko-haram to contend with [25].

Analysts believe, the country's leadership has not taking a decisive step to assist these communities that need help, given, the insurgency has created huge fear and sense of insecurity amongst not only inhabitants, but volunteers and other health professionals who are working assiduously to ensure successful implementation of the MDGs in these areas.

#### **5.4 Inaccessibility**

The last theme of analysis is inaccessibility. Literarily inaccessibility means the state of unattainable, or not available when needed [26], and un attainability has given a clearer meaning of the challenge poses on the implementation process. The terrain of Brass under review has a known topography that consists of mangrove, narrow creeks, the persistent high sea waves and of course, the sea pirates as well as the hostile military presence due to the insurgency. Meaning, getting to the area involves huge amount of money and transportation in the face of scarcity of fund [18].

Although, these might result from poor financing of health services/ programmes, corruption/ misappropriation, some of or all of these could cause inaccessibility to the health care facilities of both workers and those who need these services in the area [17].

“inaccessibility to antiretroviral [ARV's]-drugs and other facilities due to difficult terrain” [16].



Access to health care facility, personnel or services are viewed as key dimension of quality to effective service delivery [26,27]. To ensure fairness and equity of health related MDGs to all, especially for services directed at the vulnerable group such as women of reproductive age and children of any age, access to health services are incontestable and should not be undermined [28]. Competence, effectiveness, support system strategies, continuity of care, good interpersonal relationship efficiency and safety cannot be achieved or measured without access to health care as indicated by the framework [28].

Whatever, the cause of inaccessibility in this context, should be corrected given-, inaccessibility will discontinue care of those infected with the Virus. Such as precipitating disabling conditions to developing disabilities, high cost of obtaining services to those already seen as living below average and increase antenatal and mental complications.

Furthermore, geographical accessibility promotes health related MDG services utilization, given, it is near to the people [reaching the hard to reach population with services] as possible especially into remote areas [29]. While social accessibility ensures that the health related MDGs services are easily accessible to all irrespective of their socio economic and cultural status [29]. The fact that inaccessibility is one challenge to the realization of 2015 target of the health related MDGs calls for an urgent attention to address the issue, given inaccessibility degrades the quality of life by mopping up the low income group's income and promotes inequality as the group concern might not have the means to get these services.

## **6. CONCLUSION AND RECOMMENDATION**

This review was aimed at eliciting the common challenges militating against the implementation of MDGs in rural Nigeria [Brass LGA] taking into consideration, the 2015 MDGs target is getting to an end, so as to make policy recommendations. Hitherto, the study drew out 11 challenges, 6 of them were highlighted and 4 of the challenges were discussed as earlier said for obvious reasons stated at the discussion segment. All the identified challenges are closely related to leadership lapses and its attendant consequences.

In the light of the above, this article resolutely makes the following recommendations.

Firstly, both MDGs policy makers and programme implementers can treat these discussed challenges symptomatically-; meaning addressing each as it presents in its peculiar form and feature, given, the UN have armful opportunities to treat these health related programmes holistically. Notable of such opportunities are regular seminars, workshops to train and retrain practitioners and volunteers through annual or biennial conferences, and other professional and personal development programmes. These trainings in collaboration with relevant agencies and designated institutions that have competence in knowledge acquisition, build persons on areas like performance management process and behaviour modification in order to carry the UN core values guiding the process. It will also be essential to encourage inter knowledge transfer [IKT]. IKT is a process by which one organisation or institution makes his knowledge stock to other firms to assist in job training to achieve maximum output. [30], The MDGs programme implementation needs collaboration to ensure that the 2015 health related target is actualized.

Another strength and opportunity the UN should employ to contain these challenges which this paper recommends is, to resolutely review the existing laws, expunge the obsolete ones which could no longer stand the test of time and update such ones adequately on health related programme implementation. The review should be backed by an enabling legislation by an act of parliament to guide all health related activities in every region or country. Ensure strict compliance of these policies by all parties involve and to accordingly sanction any herring country, state, LGA, community or individual volunteers. These laws should cover areas such as recruitment, selection and orientation of stakeholders, implementation that conforms with UN global practices [29]. Besides that, enabling laws, policies and regulations will enable the setting under review to embark upon sustainability and risk management programmes that will protect both human and material resources. In addition, the implementation of the health related MDGs and future programmes should be devoid of any form of corrupt practices through committed leadership and effective monitoring of programmes [30].

As regards the crisis endemic in the region, this article suggests establishing specific intervention goals regarding specific behaviours, given, prompt intervention will promote realization within a short timeframe. Secondly, stakeholders should be alert to ensure early detection of impeding crisis, irrespective of the fact, the `trademark of crisis is its unpredictability, given, the extent to which crisis affect a people are unpredictable [31,32].

In similar vein, this article recommends frantic awareness on effects of crises before its occurrence in all regions, especially where important programmes such as the MDGs and future health initiatives are to be sited, seeing awareness could motivate prompt intervention [33].

This paper also suggests, new steps to improve the efficiency of public expenditures, procurement, re-strategize delivery of simple tools like drugs, water, improve, immunization services, community-based nutrition activities as well as villages and districts in the poorer communities, where health and nutrition indicators are below the acceptable levels in an effective, broader, sustainable and easy to understand to enable interest groups track misappropriation, scrutinize and demand accountability of such resources.

Again, government can ensure the establishment of efficient price control mechanism, partner with health professionals, contractors and voluntary workers on MDGs` promptly and regularly pay them so as to expose these workers less susceptible to corruption. Health related MDG programme designers should also partner with Federal, State, relevant agencies such as National Agency for Food and Drug Administration and Control (NAFDAC) and other quality control group to avoid counterfeit. These agencies could partner in counterpart funding, lucidly promote proper accountability and transparency in execution of planned programmes to achieve the proposed target.

The above suggestions will minimize the challenges militating against the realization, if the above agencies stand up to their respective responsibility, participate actively in planning implementation and monitoring of all health related programmes, decisively step to reprimand and sanction culprits to contain the trend of corruption. Otherwise, herring groups be given timeframe to pay such monies back to the MDGs coffers.

Not only that, the protracted conflicts in the region can be resolved by bringing all aggrieved parties to air their grievances to allow peaceful coexistence. Given, it is only in an atmosphere devoid of rancho and acrimony will promote socio, economic, cultural and physical development to a people. To achieve the health related MDGs in 2015 (reduce child mortality rates, improve maternal health and fighting epidemic diseases such as malaria, AIDS and others] the leadership should endeavour to compliment the programme in order that the intended beneficiaries will access all available facilities. There should be equitable distribution of these facilities to the grass root.

Nevertheless, this article suggests further research on steps that can improve leaders for more efficient/effective health programme and service implementation.

## COMPETING INTERESTS

Author has declared that no competing interests exist.

## REFERENCES

1. Sweetland A, Ishiyaku MM. Taking concepts to scale: Achieving the Millennium Development Goals in Nigeria; 2011.  
Available:[www.hiffingtonpost.com](http://www.hiffingtonpost.com)  
(Accessed 12, July 2014)
2. Amadi. Nigeria may not achieve MDGs before 2015; A joint parliamentary briefing on millennium development goals; 2014.  
Available:[www.thisdaylive.com](http://www.thisdaylive.com)  
(Accessed 3, August 2014)
3. Ajiboye T, Nigeria`s MDGs score card; 2014.  
(Available From PM News)
4. Eboh M, [2011] UN lauds Nigeria over MDGs; The Vanguard 30<sup>th</sup> May 2014.  
[Available from Ebitare bookshop on 10,s June 2014.]
5. Wagstaff A, Cleason M. Millennium development goals for health: Rising to the challenges/The world bank pcm; 2004.  
(Accessed 15 July 2014).
- 6a Park K. Park`s textbook of preventive and social medicine [19<sup>th</sup> ed]. Jabalpur Banarsidas Bhanot publishers. 2007;11.
- 6b Park K. Park`s textbook of preventive and social medicine [20<sup>th</sup> ed]. Jabalpur Banarsidas Bhanot Publishers. 2011;15.

7. Abdulateef B. Suleiman A. Islamic Development Bank, [IDB] The challenge of achieving the Millennium Development Goals in IDB member countries. Occasion paper no. 16; 2011. Available:[www.isfd.isdb.org](http://www.isfd.isdb.org) (Accessed 15 July 2014)
8. Ugo EJ. Supervisor of MDGs programmes in Brass local government area; 2014.
9. Nipost office census information. 2009. (Available from Brass Local Government Area Accessed 10, April 2015).
10. Kawulleh BB. Data Analysis Techniques in Qualitative Research. 2005;6(2):43. Available:<http://www.qualitative-research.net> (4, July 2014)
11. Bryman A. Burgess RG. Analysing qualitative data London. Routledge; 1994. Available:[www.amazon.com](http://www.amazon.com) (Accessed 4, July 2014)
12. Patton MQ. Qualitative evaluation and research methods [2<sup>nd</sup> ed.]. Newbury Park, CA: Sage Publications, Inc; 1990.
13. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology; 2006;3:77-10.
14. Smith J. Dunworth F. Qualitative methodology; In Valsiner, J and Conolly, L[eds] Thousand Oaks. Sage; 2003.
15. Mays N, Pope C. Quality in qualitative health research; In Mays N and Pope C [eds] Qualitative research in health care; Oxford Blackwell. 2006;82-101.
16. Northouse GP. Leadership theory and practice; [online] 2012;1-421. Available:[www.sage.com](http://www.sage.com) (Accessed 11, August, 2014)
17. Stogdill RM. Handbook of leadership: A survey of the literature, New York; Free press; 1974.
18. Chidiebere EP. Millennium development goals; what are the greatest challenges in Africa. A discussion board; 2008. Available:[www.un.org/africa](http://www.un.org/africa) (Accessed 15, July 2014)
19. Lucky M. A stakeholder from the state under review; 2014.
20. Semler R. Maverick; the success story behind world's most unusual workplace. Warner books. Rio de Janeiro; 2000.
21. Nabez NS. Examining the cost and benefits of corruption in developing countries. Opinion analysis; 2012. Available:[www.ekurd.net](http://www.ekurd.net) (Accessed on 19, September, 2014)
22. Padua L. Transparency International; Brazil marching against corruption;2014. Available:[www.anticorruptionplatform.com](http://www.anticorruptionplatform.com) (Accessed on 19, September, 2014).
23. Kandra C. Definitions in Psychology; What is a crisis 2012. Available:[www.definitionsinpsychology](http://www.definitionsinpsychology) (Accessed 2, October, 2014)
24. Caplan G. Prevention of Mental Disorders in Children. New York: Basic Books; 1961.
25. BBC News Nigerian militants seize workers from oil rig; 2009 Available:[www.bbc.com](http://www.bbc.com) (Retrieved 2, October, 2014)
26. Waters H, Saadah F, Pradham M. Impact of 1997/1998 East Asian economic crisis on health and health care in Indonesia; Oxford Journal Health Policy And Planning. 2003;18(2):172- 181. Available:[www.oxfordjournal.org](http://www.oxfordjournal.org) (Accessed 2, October, 2014)
27. WHO, The World Health Report 2000; Health systems Improving Performance, Geneva; 2000.
28. Farles, Online Free Dictionary 2015, Available:[www.thefreedictionary.com](http://www.thefreedictionary.com) (Accessed 13, April, 2015).
29. Committee on Quality Health Care in America, Institute of Medicine Crossing the Quality Chasm; A New Health System for the 21<sup>st</sup> Century. Washington, D.C; National Academy Press; 2001.
30. Gareth S. Transparency international; global corruption report; 2004. Available:[gcr@transparency.org](mailto:gcr@transparency.org) (Accessed 19, September, 2014)
31. Jackson-Cherry LR, Erford BT. Crisis intervention and prevention. NJ: Pearson Education; Inc 2010.
32. George AA. Quest for quality; interventions to improve human resources for faith based organisations. Codald and royal tropical institute Netherlands; 2009.
33. Aguilera DC. Pollin Crisis Intervention; theory and methodology. Mosby, St Louis; 1999.

## APPENDIX

From the main organized texts, these highlights are extracted and collated cod-able features are segmented.

S/no	Material	From the main organized texts, these highlights are extracted and collated cod-able features are segmented	further reduced to sub- categories
1		<p>Informant; Some contractors called to execute job do not necessarily qualify in the process, but were merely called to serve as part of efforts to compensate political friends and allies. Such contacts more often than not are abandoned.</p> <p>There is the atmosphere of culture of impunity amongst these crop of contractors.</p> <p>There is problem of inter wrangling amongst communities members over project location. Some youth bodies and community members refuse contractors to take materials to their site unless some monetary compensations were paid to them.</p> <p>There is also problem of terrorism that causes panic, fear and anxiety and creates deep impression in the minds of the contractor to abandon project.</p> <p>Lack of purposeful and efficient baseline studies carried out to assess the needs of the communities before projects are carried to such location.</p> <p>There is the challenge of sustainability of projects located in localities and ineffective monitoring system.</p> <p>Differences in rules, procedures and expectations from each partners leading to non compliance to counterpart funding</p> <p>Inadequate coordination of countries and partners involved</p> <p>Lack of foothold due to one party undermines the plans and processes of other implementers</p> <p>Risk increased aid dependency and lack of sustainability by recipients</p> <p>Over publicity of programmes with no commiserate effort</p> <p>Failure of some LGAs to fully understand the implications of not knowing that health is placed as the heart of development by UN</p> <p>Inefficient in equitable revenue allocation</p> <p>Weak mechanisms for coordinating health programmes</p> <p>Minimal political commitment, uncommitted implementers/workforce, absence of social safety net</p> <p>Poor budgetary allocation- despite AOU summit declaration of 15% national yearly budgetary allocation for health programmes</p> <p>Poor risk management system and insecurity</p> <p>Minimal public private partnership in terms of resources allocation in health programmes implementation</p> <p>Inadequate remuneration</p> <p>Synergy or its lack of faith amongst the various tiers of government</p> <p>Lack of policies directed at the rural communities. [Secretary national planning commission]</p> <p>Population explosion and prolonged poverty</p> <p>Wide variation in programme coverage</p>	<p>Financial issues</p> <p>Lack of partnership</p> <p>Lack of sustainability</p> <p>Lack of commitment</p> <p>Lack of awareness</p> <p>Poor revenue allocation system</p> <p>Inadequate political involvement</p> <p>Insufficient budget to programme allocated</p> <p>Poor risk management system</p> <p>Lack of efficient baseline studies</p> <p>Lack of cooperation</p> <p>Leadership commitment</p> <p>Untrained personnel or lack of trained personnel being use as implementers</p> <p>Unskilled personnel and inadequate healthcare facilities compare to the population in need</p> <p>Financial constrains lead to</p> <p>inaccessibility to antiretroviral drugs and facility due to difficult terrain</p> <p>Stigma and discrimination</p> <p>Poor resources management</p> <p>Effective policy formulation and financial accountability, transparency, accountability, law</p>

Ingenuity of some donor agencies.

Problem of financial barrier that hinder access to healthcare services for pregnant women and under five children

Amadi, [2014] in his publication by Joint Parliamentary committee briefing states that *“Nigeria may not achieve the health related MDGs in 2015 due to corruption and other issues”*.

Secondly ibid believes, the achieving the three goals is a mirage since the goals were arbitrarily formulated

*“ considering the fact that the present goals were levelled up without any parliamentary input”*

Still in that same session Amadi, [2014] asserts *“despite the ,,,,,, “We`ve had increase in unemployment and this definitely would directly affect abilities of families to have decent standard of living”*

*“ I think, most importantly, and that is one issue we have been pushing at the Pan African Parliament, as we begin to formulate the post-2015 health related goals agenda we have to talk about the issue of governance, with the issues properly tabled. Can we begin to see how transparency and accountability in the use of public resources will affect the implementation of the MDGs? You would see that one of the major problems in our country today is corruption and mismanagement of public resources. That is a governance issue and that must be tackled.”*

*“Another biggest problems and why we have not been able to achieve as much as we should have in the MDGs is the corruption and leakage in the system. A corrupt system remains a big drain on our natural resources and a lot of that are traceable to the core enforcement of law and order.*

*There are not enough deterrents, no adequate punishment for crimes and these issues help to encourage corruption”*.

The Joint parliamentary committee viewed lack of penalties and ineffective implementation of existing ones, in which the committee describes as *“lack of deterrents”*

*“Rwanda would rise from the ashes of genocide to be able to make meaningful progress even in terms of the MDGs, not just the government, it is collective”*.

That is why we think that the Nigerian current process of partisan politics does not allow us to see anything good in any other person who is from any other political party and I think that is very wrong.

It has to be a collective thing. All Nigerian citizens, civil society, private sector, political class, we all need to come together for the benefit of our people

In a similar setting Ajiboye [2014] believes in Nigeria, we have seen some level of commitment starting from the Obasanjo-led administration to the MDGs, which has commenced in some states of the federation, a critical look at the implementation of the MDGs in Nigeria shows that much needs to be done especially now that 2015 is fast approaching

The performance appraisal of Nigeria’s fourteenth year’s journey to achieving the set MDGs is mixed. Progress towards five MDGs has been below average but progress has been less satisfactory towards the three other MDGs:

Improve maternal health. Slow progress: Success in this goal has been slow and poses greater challenge to women’s survival. However, maternal mortality fell from 800 deaths per 100,000 births in 2003 to 545 deaths per 100,000 births in 2008. Reproductive

enforcement, zeal and commitment  
Infrastructural constrains  
Poor leadership, corruption and lack of commitment  
Country’s past history and prolonged injustices setting where the implementation is taking place  
Poor policy implementation  
The socio economic, religious and political atmosphere,  
Corruption and greed  
Corruption, unqualified public servants, inappropriate policies adopted  
Bad leadership, selfishness  
Financial barriers  
Lack of credibility and poor prevention, treatment and control strategies, poor surveillance, monitoring and evaluation efforts  
Cost of disease eradication  
Ambitious and unrealistic goals  
Crisis  
Unemployment  
Poor awareness creation  
Benefitting communities not involved and not owning programme  
Lack of skilled manpower and lack of commitment,  
conflict and sea pirates- insecurity due to insurgency  
Political instability,

---

health through the use of contraceptive is at the rate of 4%. The slow pace on achieving this goal is as a result of poor medical facilities and half baked doctors and nurses.

Maternal mortality as far as Nigeria is concerned is yet to receive any boost. World Health Organisation's report says "more than 500,000 women die in pregnancy or childbirth each year, mainly because of lack of access to skilled care." Many women in Nigeria today lose their lives during childbirth particularly those in rural areas because of unavailability of adequate healthcare delivery system especially in the areas of ante-natal and post natal care.

Combat HIV/AIDS, malaria, and other diseases. Average progress: The prevalence of HIV/AIDS dropped to 4% in 2008. HIV prevalence in pregnant women aged 15-24 years also dropped to 4.2% in 2008. The proportion of the population accessing antiretroviral drugs increased to 34.4% though still very costly, basically for the elite. The percentage of children sleeping under insecticide-treated mosquito net rose from 2.2% in 2003 to 5.5% in 2008. Malaria infection rate remains steady, and has accounted for average of 300,000 deaths each year. There is considerable progress against polio and credit goes to an international organization like Rotary International.

However, if we must reverse the spread of HIV/AIDS and other diseases the fight has to be intensified and those living with the disease must be helped, and all forms of discrimination against them must be stopped

With wise management, the country can still be Africa's largest economy, and also play a significant role in the global economy. Be that as it may, the present administration of President Goodluck Jonathan should re-position the economy of the country through the formulation of effective policies and programmes to steer Nigeria to greater height. The principle of accountability, transparency and respect for the rule of law should be upheld and most importantly enforced. It should be able to pursue the health related MDGs with utmost zeal and seriousness.

In another article, Chidiebere [2008] believes the greatest challenge to the achievement of the MDG'S are basically infrastructure constraints. We all need to add our voice to push Governments, individuals and especially corporate organisations to contribute by providing infrastructure

Africa is her own enemy in terms of the MDG's. With the kind of leadership we see in Africa-the rate of corruption and waiting for other people to chart the course of our wellbeing is our downfall.

We need to understand the issues that are affecting us and prescribe the right medicine. Its amazing that Africa has 80%of the resources in the world yet we are the poorest continent.

We need to answer the question why are we poor? the issue of history come into play. The issue of economic injustice has to be analysed well. Africa has a debt where did it come from?

We are the richest continent just look at the modern day scramble for Africa. So how can we achieve the MDG's considering all these, which are against us? remember our economies were prescribed with a Harvard university student's thesis called ESAP and where did that took us? its high time we start to look for and implement home grown solutions then we might achieve the MDG"s. i rest my case.

non sustainability,  
lack of succession  
planning

Programme  
abandonment.

---

Have also seen the problem of non implementation of policies as a stumbling block to our achieving the MDG's..We have so many brilliant policies and ideas gathering dust in the offices our governments. These just need implementation.

basically it ends with corruption and greed not only by the ruling class, but also the business society and individuals.

With corruption you see unqualified public servants who are the policy makers, business people who oil the hands of state officials to get lucrative tenders then do a shoddy job etc. another problem could be the policies that African governments have adopted, for a business to be up and running in some countries, you need more than 5 licenses and application for these licenses require money and at least 3 weeks for each license to be processed. i need not to talk about access to credit since it is a nightmare.

bad leadership with no focus for the people.....selfish interest

by addressing the critical problem of financial barrier that hinder access to healthcare services for pregnant women and under five children

Many governments lack credible and resource backed strategies for the prevention, treatment, and control of communicable diseases.

- Too little effort is devoted to surveillance, monitoring and evaluation, learning the lessons of such exercises,

If the lack of interventions is not holding countries back from achieving the goals, what is?

lack of government health spending is

only part of the story of low coverage rates. [World, Bank & Wagstaff and Cleanton , 2004]

The cost of eradicating this is a huge challenge for IDB Group requiring intensifying efforts to raise funds, leveraging partnerships

with development partners and the private sector and perhaps,,,,,,,,,,,,,

**MDG targets are ambitious and unrealistic [IDB, 2007 ]**

“without access to safe drinking water” [World Bank, 2010].

Based on global scenarios, the World Bank [2010] also compared the pre- and

post-crisis outlook of health in developing countries. It observed that the

impact of the crisis on health was severe.

Before we turn to assess the impact of the crisis on MDGs in member countries,

Impact of the Crisis

The UK’s Department of International Development [DFID] estimates the total number

of newly poor at 90 million following a 4.5% deceleration in GDP growth in developing

countries using the World Bank’s estimate of 1% less growth = 20 million more poor people

---

---

[DFID, 2009]

The World Bank revised its estimates of the actual number of newly poor since the crisis

from 53 to 65 million, based on the \$2 a day poverty line, and from 46 to 53 million based

on the \$1.25 a day poverty line [World Bank, 2008]

The UN Educational, Scientific and Cultural Organization

[UNESCO] estimates a 20%,

or \$46, drop in per capita income for the 390 million poor people in sub-Saharan Africa

[UNESCO, 2009]

The International Labour Organization [ILO] estimates a rise in global unemployment from

18 million to 51 million [ILO, 2009]

The World Bank predicts that the crisis could result in 200,000–400,000 extra infant deaths

per year. A 1% fall in GDP growth will lead, on average, to the deaths of an additional 1.5

boys and 7.4 girls per 1000 live births [World Bank, 2009]

Source:

[http://www.thebrokeronline.eu/en/Magazine/articles/Beyond-2015/Poverty-impacts-of-theglobal-](http://www.thebrokeronline.eu/en/Magazine/articles/Beyond-2015/Poverty-impacts-of-theglobal-financial-crisis)

[financial-crisis](http://www.thebrokeronline.eu/en/Magazine/articles/Beyond-2015/Poverty-impacts-of-theglobal-financial-crisis)

Informant from the State under review said, the MDGs covers health, water and sanitation

Awareness is not there [on the part of the rural dwellers] where most of the projects are sited.

Rather than getting involved as partners so as to take ownership of the provision, they rather sabotage the job by way of vandalizing the water boreholes installed at the various health centres.

In some instances, because of the difficult terrain, it takes days to get to the designated health centres to either deliver drugs, medical equipment or hospital furniture.

At times, even when the delivery team gets to the health centre to deliver drugs, there may be no health worker present on ground to receive the drugs. Where we insist and even drop the drugs the drugs might be on the floor onto expiration.

Another challenge we face while rendering these services in the area coming in conflict with thieves [sea pirate]. In such circumstance, all we hard on the boat will be destroyed by the miscreants.

Lastly political in stability and programme discontinuity. As a result of frequent changes in the leadership, the successive governments oftentimes formulate its new policies and programmes rather than to continue and build upon existing ones embarked upon by their predecessors. In serious cases, the old programmes are abandoned for the new ones. Although that factor has not been prominent with the State MDGs. We only encountered few cases from the previous administration.

Still in the state under review, the MDGs covers health

---



Step 3

In step 2, one can figure out similar words and phrases from the extracted texts.

Table 3 Step 3 further reduced the extracts to development of themes in groups as below. The themes are re- grouped with colours for easy identification and creation of major themes for analysis.

<b>Collated sub-themes</b>	<b>Main themes for analysis</b>
<b><u>Financial issues identified</u></b>	
Poor revenue allocation system	1 Financial issues
Insufficient budget to programme allocated	
Financial constrains	2 Leadership issues
Poor resources management	
financial accountability,	
Financial barriers	
Cost of disease eradication	
Unemployment	
<b><u>Leadership issues;</u></b>	
Lack of sustainability	3 Corruption issues
Lack of commitment	4 Crisis
Inadequate political involvement	5 Policy issues
Poor risk management system	6 Manpower issues
Leadership commitment	7 Lack of partnership
zeal and commitment	8 Awareness issues ;
Poor leadership, lack of commitment	9 The socio economic, religious and political atmosphere,
Country's past history and prolonged injustices	10 to inaccessibility to antiretroviral drugs and other facilities due to difficult terrain
inappropriate policies adopted	Infrastructural constrains
Bad leadership, selfishness	11 Stigma and discrimination
Lack of credibility and poor prevention, treatment and control strategies, poor surveillance, monitoring and evaluation efforts	
Ambitious and unrealistic goals	
Benefitting communities not involved and not owning programme	
lack of commitment,	
Political instability, non sustainability, lack of succession planning	
Programme abandonment.	
<b><u>Corruption issues</u></b>	
transparency,	
corruption	
Corruption and greed	
Corruption, compensations	
<b><u>Crisis</u></b>	
conflict and sea pirates- insecurity due to insurgency, terrorism	
<b><u>Policy issues</u></b>	
setting where the implementation is taking place	
Poor policy implementation	
inappropriate policies adopted law enforcement	

**Manpower issues**

unqualified public servants  
Lack of skilled manpower  
Untrained personnel or lack of trained personnel being use  
as implementers  
Unskilled personnel, incompetence

**Lack of partnership**

Cooperation

**Awareness issues ;**

lack of awareness  
Poor awareness creation

The socio economic, religious and political atmosphere,

**to inaccessibility to antiretroviral drugs**

Infrastructural constrains

Stigma and discrimination

---

© 2015 Wankasi; This is an Open Access article distributed under the terms of the Creative Commons Attribution License [<http://creativecommons.org/licenses/by/4.0>], which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

*Peer-review history:*

*The peer review history for this paper can be accessed here:*

*<http://sciencedomain.org/review-history/10118>*