ISSN NO.2395-0692
International Journal of Arts, Humanities and Management Studies
IJAHMS

Implementation of 2004 Revised National Health Policy in Katsina State, Nigeria: Results and Challenges

Amina Lawal Mashi* & Rohana Bt. Yusof**

Department of Sociology, Umaru Musa Yar'adua University, Katsina, Nigeria.
*****Northern Corridor Research Centre, Universiti Utara Malaysia,06010 UUM Sintok, Kedah DarulAman.***

ABSTRACT

The Katsina state government as one of the state in Nigeria implemented the 2004 Nigerian National Health Policy, which seeks to reduce maternal mortality ratio by 66% within ten years of its implementation as one of its targets. The study therefore seeks to achieve the following objectives: to determine if the health target on maternal mortality ratio has been achieved, to examine the factors that contributed to the reduction of the maternal mortality ratio, and to make appropriate recommendations. Method: The data for the research was collected via primary sources i.e a field research work carried from the two-referral hospitals (General hospital and Turai Musa Yar'adua Children and Maternity Hospital). A mixed research methods was used i.ean open-ended questionnaires and in-depth interview with officials of the hospitals. A total of 367 questionnaires were administered on pregnant women, also an in-depth interview was held with four top officials (2 Medical directors and2 chief nursing sisters of the hospitals). Findings: The research found reduction in the level of maternal mortality ratio by 1.5% or 1 death per 68 deliveries maternal mortality ratio (MMR), involvement of NGOs, demonstration of modest government political will. Recommendation: government should encourage community participation, allocation of more resource.

Keywords: *Maternal Mortality, NGOs, 2004 Nigeria National Health Policy*

INTRODUCTION

As at the year 2000 the world's estimated maternal mortality ratio was 529,000, and that half of this estimate was found to be largely existing in developing countries i.e. Africa (i.e. 251,000 MMR),Asia (i.e. 253,000 MMR), Latin America (i.e. 22,000) and only less than 1% was attributed to developed countries of Europe and America. Furthermore, it was also revealed that India has the highest maternal mortality ratio of 136,000 and then followed by Nigeria with 37,000. Other countries that account for 67% world's maternal death are Pakistan (26,000), Democratic Republic of Congo and Ethiopia (24,000 each), the United Republic of Tanzania (21,000), Afghanistan (20,000), Bangladesh (16,000), Angola, China and Kenya (11,000 each), Indonesia and Uganda (10,000 each). (WHO et al, 2003).

In order to address the above reproductive health challenges, the United Nations organized various international conferences where conventions aimed at developing health policies and strategies to improve women's health within its member states over a period. Some of these

www.ijahms.com

conventions includes the United Nations Millennium Declaration/Development Goals (2000); Paris declaration (2005); the second primary health care revolution (2006) (Aneikwu, 2005; WHO, 2008). These conventions therefore, served as inspiration to member states of the UN by implementing various health policies to improve the reproductive health of their citizens. Nigerian government had for example, over the past three decades, formulated and implemented a number of health policies with the sole aim of improving its health care system; one of such policies was the 2004 Revised National Health Policy (Federal Ministry of Health, 2004).

This study therefore, sets out to evaluate the impact of implementation of the 2004 Revised National Health Policy, concerning reduction of maternal mortality ratio, from two secondary/referral health care hospitals located in Katsina State, North-West zone of Nigeria, in view of zone's high records of maternal mortality ratio.

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The theoretical framework of Sabatier and Mazmanian (1980),was regarded as most relevant for the study, as it recognizes certain factors, which could affect the outcome of implementation process of a policy. Some of these factors include the level of political will demonstrated by the government during the period of the implementation process; resources allocated both human and financial, effects of socio-cultural and socio-economic factors on the implementation process etc.

Maternal Mortality

According to WHO (2007), maternal mortality simply means women's death due to pregnancy and pregnancy related causes and it constitutes a major cause of death amongst women of reproductive age; thus becoming one of the serious health issues particularly in developing nations. In addition, maternal mortality has been seen as death of women during pregnancy and or within 42 days after termination of pregnancy (Hogan et al. 2010). Similarly, maternal mortality ratio is also referred to as the number of maternal death recorded annually per 100,000 live births. World's estimated statistics of maternal mortality ratio of 430 maternal per 1000 live births shows that developing countries have high ratios of 403 maternal deaths, while the developed countries have 27 ratios of maternal deaths. The world health organization (WHO, 2014) reported that millions of women die globally every year due to complications related to pregnancy; 99% of these women are from the developing countries (WHO, 2014). The highest maternal mortality levels are found in parts of India, eastern and western Africa, while the lowest level occurs in northern Europe with some parts of developed countries of the world (less than 4 per 100,000 birth in Finland (Nimi Briggs, et al. 2008).

Similarly, African region, according to WHO et al (2005), has the highest maternal mortality ratio in the world. Maternal mortality ratio varies between developed and developing countries because developed countries have their excellent health care system, while the developing countries have weak health system (Graham, et al. 1987). This clearly shows that maternal mortality can be avoided if adequate resource can be allocated to hospital so that they can render quality health services. Nigeria has the highest maternal mortality ratio in Africa of 1100 MD/100,000 live births. Similarly, 186 children per 1000 live births die by the age of five in Nigeria, thus making Nigeria to be one of the country with worst records of maternal and child

www.ijahms.com

deaths in the world (CIA world fact book, 2011). Consequently, African region tops the list of countries with higher rates of MMR and motherly death with Asia region coming second, while Europe has the least rate of MMR and maternal death.

It is however, interesting to note that some countries have succeeded in reducing their maternal mortality ratio by adopting different strategies such as encouraging skilled attendants to provide obstetric services particularly to women living in rural areas. For example, Indonesia developed a maternal health policy change in 1990s to address incidence of high maternal mortality and the success rate was quite impressive as access to maternal health care increased thus reducing maternal mortality. This impressive result was achieved using a strategy of deploying 50,000 village midwives to carter for the health needs of women in the rural areas (Starr, 1998).

Similarly, Koblinsky (2003) reported that countries such as Malaysia, Sri Lanka and Hondurus took a strategy of reducing maternal mortality through the provision of skilled birth attendants, birthing facilities, and establishment of referral links within the communities. While in the same vein, Pakistan provided health facilities at district levels in rural areas. Furthermore, Egyptian government also formulated a comprehensive health policy from 1988 to 2002 designed to reduce maternal mortality. This initiative resulted in drop of maternal mortality by over 50 per cent, from 174 in 1992 to 84 per 100,000 live births in 2000 (Ministry of Health and population, Egypt, 2002).

Causes of Maternal Mortality

The factors that causes maternal mortality are broadly grouped into two: direct factors and indirect factors. According to Osungbade, Oginni&Olumide (2008); Garenne (1997) and Callister (2010), direct causes of maternal death are obstetrical complications such as hemorrhages, infections, abortions performed by unqualified health personnel, eclampsia and prolonged labor. Indirect factors of maternal mortality include diseases and infections such as malaria, HIV/AIDS, hepatitis, and anemia. Kullima, et al. (2009), identified eclampsia (i.e. Complication of pregnancy) as one of the major factors of maternal and prenatal death in Nigeria.

METHODOLOGY

Mixed research methods were used during the data collection - 367 questionnaires were administered on pregnant women, also an in-depth interview was held with four top officials (2 Medical director with 2 chief nursing sister of the hospital).The questionnaire for the beneficiary women was administered by the researchers in Hausa Language (as most of them were not literate), while the in-depth interview with the officials of the hospitals was conducted in English Language. The questionnaires were analyzed and the results presented in a tabular form and narrations, with the women responses coming first, followed by the interview conducted with the officials of the hospital.

www.ijahms.com

DATA ANALYSIS AND RESULTS

Quantitative: Responses from pregnant Women

Questionnaires were administered on 367 pregnant women from two referral hospitals and below are the responses received, presented in a tabular form.

Table 1 *Effects of Government Political Will*

Category	Frequency	Percentage
Strongly Disagreed	20	5.4
Undecided	34	9.3
Disagree	230	62.7
Agree	67	18.3
Strongly Agree	16	4.3
Total (N)	**367**	**100.0**

The above table shows that majority of the respondents i.e. 230 or 62.7% disagreed with the statement that government did not provide much political support during the implementation of the policy, while 67 of the respondents representing 18% agreed with the statement that government did not provide much support.

Table 2 *Effect of Insufficient Funding on Maternal Mortality*

Category	Frequency	Percentage
Strongly Disagreed	7	1.9
Undecided	20	5.5
Disagreed	98	26.7
Agree	124	33.7
Strongly Agree	118	32.2
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 124 or 33.7% and 118 or 32.2% respectively) agreed and strongly agreed respectively, that there was insufficient funding of the health sector by the government which could have affected the overall success of the policy especially rural areas.

Table 3 *Effects of Insufficient Infrastructure*

Category	Frequency	Percentage
Strongly Disagreed	10	2.7
Undecided	10	2.7
Disagree	44	12.0
Agree	130	35.4
Strongly Agree	173	47.1
Total (N)	**367**	**100.0**

www.ijahms.com

From table above, majority of the respondents (i.e.173 or 47.1% and 130 or 35.4%) strongly agreed and agreed respectively that insufficient well equipped hospitals affected the implementation of 2004 revised national health policy particularly with regards to reduction of MMR.

Table 4 ***Effects of Insufficient Health Personnel***

Category	Frequency	Percentage
Strongly Disagreed	4	1.1
Undecided	6	1.6
Disagree	59	16.1
Agree	183	49.9
Strongly Agree	115	31.3
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 183 or 49.9% and 115 or 31.3%) agreed and strongly agreed respectively that insufficient health personnel in the health sector had affected considerably the implementation of the policy.

Table 5 ***Impact of Socio Cultural Factors.***

Category	Frequency	Percentage
Strongly Disagreed	5	1.4
Undecided	13	3.5
Disagree	41	11.2
Agree	134	36.5
Strongly Agree	174	47.4
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 174 or 47.4% and 134 or 36.5%) strongly agreed and agreed respectively that socio-cultural factors affects utilization of health care facilities by pregnant women especially those living in rural areas, thus leading to complications and sometimes death.

Table 6 ***Effect of Lack Education and Awareness on Health Care Access***

Category	Frequency	Percentage
Strongly Disagreed	8	2.2
Undecided	12	3.2
Disagree	49	13.4
Agree	106	28.9
Strongly Agree	192	52.3
Total (N)	**367**	**100.0**

Table above, indicates that majority of the respondents (i.e. 192 or 52.3% and 106 or 28.9%) strongly agreed and agreed respectively that lack of education and awareness affects access to health facilities by pregnant women.

www.ijahms.com

Table 7 *Effects of Non-Governmental Organization on Health Care*

Category	Frequency	Percentage
Strongly Disagreed	8	2.2
Undecided	15	4.1
Disagree	30	8.2
Agree	151	41.1
Strongly Agree	163	44.4
Total (N)	**367**	**100.0**

From table above, indicates that majority of the respondents (i.e.163 or 44.4% and 151 or 41.1%) strongly agreed and agreed respectively that Non-Governmental Organizations are complementing the efforts of Katsina state government through the provision of facilities such as beddings, building of theatre rooms, hospital equipment, wards, drugs and injectables.

Qualitative: In-Depth Interview with Hospital Officials

Four officials of the twohospitals (2 Medical Directors i.e. MD_1 and MD_2) and 2 Chief Nursing Sisters (i.e.CNS_1 and CNS_2), selected for the study were interviewed. The interviews was conducted in the offices of the officials at their respective hospitals. Therefore, the interview responses are presented below using the following abbreviations: MD and CNS to signify (Medical Director and Chief Nursing Sister) of the three hospitals under each question asked:

1) Political Support on the Implementation of the Health Policy on Reduction of MMR?

First respondents testifies that:

> *"The government is doing its best within its financial resources. They pay salaries and allowances of staff, provide free maternal care from ANC to delivery, free blood and drugs etc."*(MD_1)
>
> Furthermore, it was stated that *"…Well the government recruits the health staff and pays their entitlements in addition, to maintenance of the hospital".* (CNS_1)
>
> *"…As far as I am concerned government is doing very well. It built this specialist hospital to take care of children and pregnant women. This is in addition to supply of free drugs free ANC, free operations during pregnancy".* (MD_2)
>
> *"…That through the coloration policy of the state government and NGOs, the NGO have been providing seminars and training to our Nurses. It also provides drugs, equipment etc. that are used during ANC and child delivery".* (CNS_2)

2) Effects of Physical Infrastructure, Equipment and Vehicles?

First respondent said that:

> *"The government has built so many hospitals in both urban and rural areas of the state. 31 Primary Healthcare Centres, 361 dispensaries had been*

www.ijahms.com

ISSN NO.2395-0692
IJAHMS International Journal of Arts, Humanities and Management Studies

constructed and are functional. 3 Primary Healthcare are under construction". (MD_1)

While another respondent said that:

"I don't have exact number of hospitals built by the government, but they are many". (CNS_1)

Another respondent added that:

"I don't know the number of hospital. But this hospital was built as a specialist hospital for children and pregnant woman. Ask Ministry of Health for the numbers". (MD_2)

However, this respondent stated that:

"There are many government hospitals in the state. It has also purchased ambulances for the bigger hospitals and mobile clinic vehicles that go around major towns and villages mostly on market days to attend to sick people". (CNS_2)

It is therefore clear, that there is insufficient health infrastructures in the state.

3) Staffing of Health Personnel in the State?

The respondents stated that:

"I am not in a position to know exact number of health personnel in the state. However, what we have in this hospital is not adequate. This is why you see patients spending hours to see doctors". (MD_1)

"In the maternity section, he still needs more nurses and other health attendants". (CNS_1)

"You can see the number of pregnant and nursing workers on the queue. The nurses are too few and over worked. We need more hands". (MD_2).

"It is therefore very clear that there are insufficient health personnel in these hospitals". (CNS_2)

4) Rates of Maternal Mortality since the Initiation of the Implementation of the Policy?

The respondents said that:

"From 2009 – 2014, the number of pregnant women coming to the hospital for ANC/ child delivery has increased". (MD_1)

He added that:

"From 2009 – 2015, 17,903 delivered in our hospital and the total maternal death was 227. So based on this figures you can notice tremendous reduction in maternal mortality rate". (MD_1)
"...More pregnant women are now coming to the hospital for ANC and delivery. Very few die. So I believe the maternal death has dropped significantly". (CNS_1)

www.ijahms.com

"Within the last five years 2009 – 2010 a total number of 15,972 pregnant women achieved in the hospital, and out of this only 269 died. So there is improvement in reproduction health". (MD_2)

He also added that:

"That is, we still need more staff to cope with the high number of pregnant women, so based on medical records these hospitals i.e. 17,903 + 15,972, a total of 33,875 deliveries in this hospital. While a total of (227 + 269) 496 pregnant women died during child birth. This translates to a ratio of 68:1 death per delivery to only 1.5% of pregnant women died during delivery. Records attached in appendixes". (MD_2)

"Maternal death is dropping because pregnant women attend the hospital for ANC and delivery". (CNS_2)

5) Effects of Socio-Cultural Factors/Practices on the Policy Implementation?

The respondents said that:

"The government and some NGOs have carried a lot of sensitization programmes to educate men, women and communities on safe pregnancy. This has helped to increase access to hospitals by pregnant women at least within the urban areas". (MD_1)

"Within the cities, socio-cultural beliefs based on religious and cultural beliefs are slowly fading away. Many pregnant women now come to the hospital for ANC and delivery". (CNS_1)

"It appears that women are being educated on safe motherhood. We now have long queues of pregnant women as early as 7:00pm to do ANC". (MD_2)

"The issues of socio-cultural factors are dying down in urban areas; pregnant women now understand the benefits of ANC and delivering in government hospital under experience health personnel". (CNS_2)

Their views suggest that socio-cultural factors still plays significant role in depriving pregnant women from going to hospitals.

6) Effects of Socio-Economic Factors on the Policy Implementation?

The respondents said that:

"Poverty is very prevalent in the state. In fact they affect access to healthcare by people generally but in particular pregnant women". (MD_1)

"The government has realized the effects of poverty on access to hospital, introduced free medical care to pregnant women from ANC to delivery stages". (CNS_1)

"Socio-economic factors such as lack of income and illiteracy seriously still discourages many pregnant women from access to healthcare. Happily

government provides free ANC, drugs and surgery to all pregnant women". (MD_2)

"Many women cannot pay the user fees charged. So this discourages them or forces them to deliver at home in rural areas where hospital does exist". (CNS_2)

7) Support Hospitals Been Receiving From NGOs and Wealthy Individuals?

All the respondents said that:

"The state government having realized that it cannot shoulder responsibilities of reproductive health alone, nevertheless it had also encouraged deliberate collaboration with NGOS and wealthy individuals. And they are really helping in areas of free drug and blood supply, sensitization etc."(MD_1)
"…Advocacy groups are helping in many areas including building of operating theatres, beds, chairs for ANC etc."(CNS_1)
"…Without the assistance the hospital has been receiving it would have been difficult to reduce MMR".(MD_2)
"They have been very helpful in many areas. We thank them for their support". (CNS_2)

8) Success rate achieved during the implementation period concerning reduction of materialmortality?

The respondents said that:

"Although I don't have the overall success rate of the state, in this hospital based on our records of ANC and delivery in the last five years, I can say we have achieved quite a lot. More pregnant women are coming to the hospital for ANC and delivery". (MD_1)

"Quite a lot have been achieved more women are delivering in the hospital but fewer women are dying during child birth". (CNS_1)

"From our medical records, you can see that in five years i.e. 2009 -2014 a total of 15,972 women delivered, while only 269 died. We may have not reached the target of the policy, but the figures are encouraging signs that we are on the right path". (MD_2)

"You can see for yourself the number of pregnant women now waiting for antenatal (ANC). We are always busy here. It shows high access to health care by the pregnant women. (CNS_2)

9) Challenges that Affected the Implementation Process of the Policy?

They mentioned that:

"We encountered problems such as insufficient funding and health personnel". (MD_1)

www.ijahms.com

ISSN NO.2395-0692
IJAHMS International Journal of Arts, Humanities and Management Studies

"Shortages of staff which leads to job stress among the few nurses we have at the maternity section". (CNS_1)

"The problems facing the hospital are same with every government hospitals i.e. insufficient funding insufficient nurses and doctors, poor power and water supply as well as inadequacy in drugs and injectables". (MD_2)

"Our problems are many but we are managing to do our jobs". (CNS_2)

10) Recommendations Offer for Further Improvements?

The respondents all said:

"Government should equip its hospitals located in Local Government Areas of the State. Bulk of the women resides in rural areas and local government headquarters". (MD_1)

"In additional funding and supply of drugs is essential if we desire high access to healthcare units". (CNS_1)

"Recruitment of more health personnel and improving expanding infrastructure would go a long way to make our hospital deliver quality health services".He added that: 2.5% health talk should be introduced on companies and wealthy individuals". (MD_2)

"We need more staff (nurses) in particular". (CNS_2)

DISCUSSION OF FINDINGS

Although Katsina state government demonstrated strong political will during implementation process of the policy, as pointed out by majority of the respondents through various policy initiatives such as provision of free ANC, free child delivery, free drugs etc. However, the study found that there were some challenges that affected the overall success of the implementation process. Insufficient funding of the health sector of the state was one of the biggest challenges as the level of funding through the Katsina state annual budgetary allocations from 2009 to 2014 to the health sector was less than 15% UN recommended figure. Similarly, the study also found the existence of insufficient of Physical Infrastructure and Consumables, as the number of hospitals and primary health care centers established by the state government are too few to carter for the health needs of a population of about 7 million people, out of which about 50% are made of women.

With regards to Health Personnel, **t**he study found the existence of insufficient health personnel particularly doctors who are constantly resigning their appointments from the services of the state government, as pointed out by both pregnant women and government officials. For example there are only 31 medical doctors to carter for the needs of the 7 million people of the state. Similarly, socio-cultural factors and socio-economic factors are still prevalent and constituted serious hindrance to access to health services by majority of women. Socio-cultural practices commonly reported by the respondents included lack of permission from husbands/family members in areas such as delay in taken decisions to take the woman to go to hospital because of availability of traditional birth attendant who is relied upon to manage the delivery of the child,

www.ijahms.com

delay in sourcing for money to take care of hospital expenses including transportation cost and finally appropriate means of transporting the affected woman as most of the rural areas of the state lack motor able roads. These three delays(i.e. delay in taking decision by her husband/members of the family to take the woman to the nearest health care institutions, lack of transport or lack of motor able roads, and the third delay happened in the hospital due to insufficient health personnel and facilities).These delays are universally acknowledged as the most pronounced factors affecting safe motherhood and are more prevalent in rural areas.

These findings confirmed findings of earlier findings of past studies on reasons responsible of failure of most health policies implemented over the years in developing countries like Nigeria (Welcome, 2011; Obansa & Orimisan 2013; Gender Nigeria Report, 2012; WHO, 2005).

However, the good news was that Advocacy Groups particularly NGOs played a significant role in salvaging the situation through various initiatives which complimented the effort of the state government in areas such as provision of health infrastructure (i.e theatre rooms, hospital equipment), drugs and injectables, training programs of medical personnel, counseling and sensitization. This had resulted in reduction of MMR by 1.5% or 1 death per 68 live births.

RECOMMENDATIONS

There is the need for the state government to demonstrate greater political will by increasing the annual budgetary spending allocated to the health sector.

Establishment of more health facilities in rural areas to carter for the needs of rural women, who cannot easily access health care facilities in towns and cities due to a number of reasons.

Finally, a more holistic approach involving all stakeholders should be adopted aimed at stamping out completely and if possible to zero level cases of maternal mortality.

CONCLUSIONS

The findings of the implementation of the 2004 revised national health policy from two reference hospitals of the Katsina State. General hospital Katsina, Turai Umaru Musa Yar'adua child and maternal hospital, showed that some achievement with respect to reduction of maternal mortality ratio as the maternal mortality ratio had been recorded, i.e. moderate reduction of MMR i.e. only 1 maternal death out of 68 live birth or an MMR of 1.5%, from the medical records of General Hospital Katsina and Turai Yar'adua Children and Maternity hospital Katsina respectively. The reduction of MMR could be attributed to two main reasons firstly, the modest political will provided by the Katsina State Government through various intervention initiatives such as provisions of free medical care to all pregnant women, collaboration with NGOs in areas of health staff training, equipment and drugs supply, mass awareness campaign to sensitize women on benefits of going to hospitals and safe mother, etc. However, the implementation process of the policy suffered some challenges such as insufficient finding of the health sector by the state government, effects of socio-cultural factors and socio-economic factors particularly among rural women, insufficient health infrastructure etc.

www.ijahms.com

REFERENCES

i. Aneikwu, N.I. (2005).The Convention on the Elimination of All Forms of Discrimination against Women and the Status of Implementation on the *Right to Health Care in Nigeria. 13*(3): 34 – 39

ii. Callister, l. C. & Edwards, J.E. (2010). *Achieving Millennium Development Goal-5, the Improvement of Maternal Health 39*(5), 590-8; quiz 598-9

iii. CIA world fact book (2011). Nigeria: people Retrieved from *https://www.CIA.gov/library/publications/the-world-factbook/geos/ni.html*

iv. Federal Ministry of Health (2004). National reproductive health policy and strategy to achieve quality reproductive and sexual health for all Nigerians Abuja Nigeriaretrievedfrom*http://www.youthpolicy.com/Policies/Nigeria%20National%20Reproductive%20Health%20Policy%20and%20Strategy.pdf*

v. Garenne, M., Mbaye, K., Bah, M. D. & Dakar Correa, P. (1997). Risk factors for maternal mortality*: a case control study in hospitals (Senegal) reproductive health 1*(1), 14-24Retrievedfrohttp://www.ncbi.nlm.nih.gov/pubmed/10214399

vi. Gender Nigeria Report (2012). Improving the lives of Girls and Women in Nigeria. Retrievedfrom*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67333/Gender-Nigeria2012.pdf*

vii. Goodburn, E., & Campbell, O. (2001). Reducing maternal mortality in the developing world: sector-wide approaches may be the key. *British Medical Journal*, *322*(7291), 917.

viii. Graham, W. & Airey, P. (1987). Measuring Maternal Mortality: *Sense and Sensitivity Health Policy And Planning 2*(4): 323-333. Retrieved from http://heapol.oxfordjournals.org/content/2/4/323.abstract

ix. Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M. ... & Murray, C. J. (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *The lancet*, *375*(9726), 1609-1623

x. Koblinsky, M. A. (2003). *Reducing Maternal Mortality, Learning from Bolivia, China, Egypt, Hondurus, Indonesia, Jamaica, and Zimbabwe* Washington, D. C.,theWorldBanOnal,1927279retrievedfromhttps://openknowledge.worldbank.org/bitstream/handle/10986/15163/multi0page.pdf?sequence=1

xi. Kullima, A. A., Kawuwa, M. B., Usman, H., &Geidam, A. D. (2009). A 5 Year Review of Maternal Mortality Associated with Eclampsia in A Tertiary in *NorthernNigeriaAnnAfrMed.8*(2)814Retrievedfromhttp://www.ncbi.nlm.nih.gov/pubmed/19805936

xii. Ministry of Health and Population Arab Republic of Egypt, (2002). *Health facility survey on outpatient childcare* (IMCI) services Retrieved from http://applications.emro.who.int/dsaf/dsa364.pdf

xiii. Nimi Briggs (2008). *Implementing the Millennium Development Goals with Respect to Women's Health* Retrieved from http://www.nimibriggs.org/implementing-the-millennium-development-goals-with-respect-to-womens-health/

xiv. Obansa, S. A., &Orimisan, A. (2013). Health Care Financing: Prospects and Challenges. *Mediterranean Journal of Social Sciences,* *4*(1), 221-236. doi:doi:10.5901/mjss.2013.v4nlp221

xv. Osungbade, K.; Oginni, S. &Olumide, A. (2008). Content of Antenatal Care Services in Secondary Healthcare Facilities in Nigeria: Implication for Quality of Maternal Health Care. Int J Qual Health Care 20(5):346-51

xvi. Sabatier, P. A., & Mazmanian, D. A. (1980).The Implementation of Public Policy: A Framework of Analysis. *Policy Studies Journal*, 8(4), 538 - 560

xvii. Starr, A. (1998). The Safe Motherhood Action Agenda: Priorities for the Next Decade—Report on the Safe Motherhood Technical Consultation 18–23 October 1997, Colombo, Sri Lanka. New York:

xviii. WHO-World Health Organization (2014). To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the healthsystem.Retrievedfromhttp://apps.who.int/iris/bitstream/10665/112318/1/WHO_RHR_14.06_eng.pdf

xix. Tinker, A. & Ransom, E. (2002). Healthy mothers and healthy newborns: the vital link. Policy perspectives on newborn health Washington, DC: Population Reference Bureau Retrieved from http://www.popline.org/node/186919

xx. Welcome M.O (2011). The Nigerian health care system: the need for integrating adequate medical intelligence and surveillance systems. *Journal of pharm Bioallied Sci*3 (4):470-470

xxi. WHO, UNICEF, UNFPA (2003). Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA Geneva: WHO

xxii. WHO-World Health Organization (2005). WHO Multi-Country Study on Women's Health and Domestic Violence against Women, WHO Geneva Retrieved from http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

xxiii. World Health Organization (2008). Factsheet, Maternal Mortality, Department of Making Pregnancy Suffer Retrieved from http://apps.who.int/iris/bitstream/10665/70198/1/WHO_MPS_09.09_eng.pdf

xxiv. World Health Organization, (2007). The Nigerian Health System Retrieved from http://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf

www.ijahms.com