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IMPACT OF 2004 HEALTH POLICY ON MATERNAL MORTALITY IN KATSINA STATE, NIGERIA

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ABSTRACT

Concerned with the rising maternal mortality ratio among its women of reproductive age, the Nigerian government implemented several health policies, but without much success, due to several implementation challenges. This lack of success necessitated the formulation of the 2004 Revised National Health Policy, which aimed at the improvement of the Nigerian health system, reduction of maternal mortality ratio by 66% at the end of 2015 etc. The study assessed the effects of the implementation of the 2004 Revised National Health policy towards the reduction of maternal mortality ratio at the Katsina state General Hospital Nigeria, in relation to the effects of funding, effects of health infrastructure and personnel, effects of socio-economic factors in healthcare access, and role of advocacy groups in healthcare delivery. The scope of the study consisted of 100 pregnant women and 2 health officials of General hospital Katsina. The study employed mixed research method, to reach the target population. The data for quantitative analysis was collected through questionnaires which were distributed to pregnant women and analysed using Statistical package for social sciences (SPSS). While, data for qualitative analysis was collected using an in-depth interview with hospitals' officials and analysed using narrations. The study found that maternal mortality ratio reduced marginally (i.e. 1 death per 59 deliveries) in the state, insufficient resources (both human and financial), insufficient health infrastructures, low access to healthcare facilities by pregnant women. The study recommends more funding and provision of health infrastructure and personnel, as well as more collaboration with both international and local Non-Governmental Organisations in the areas of sensitization of women and training of health personnel, as well as provision of health infrastructure.

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Keywords: Health Infrastructure, Maternal Mortality Ratio, 2004 Health Policy Implementation, Socio-economic Factors.

INTRODUCTION

Over the years concerted efforts had been made with significant success by the World Health Organization, its member states and various Non-Governmental Organizations to eradicate or reduce the spread of communicable and preventable diseases such as smallpox, HIV/AIDS etc., thus saving lives of millions of people particularly in developing countries (Phillip, 2012). However, little progress has been made with regards to tackling maternal mortality ratio (MMR), as still millions of women globally die due to causes related to pregnancy and childbirth. In sub-Saharan Africa, and south Asian countries, it was reported that more than eighty-five percent of maternal deaths were pregnancy related, in contrast with developed countries of Europe and America that had less than 1% MMR. Similarly, it was estimated that about 800 women die per day, more than 30 women die every hour and that (WHO, 2012). Even in developing countries, it was reported that India has the highest maternal mortality ratio of 136,000 and then followed by Nigeria with 37,000 (WHO et al. 2003).

The above grim picture prompted the United Nations to organize various international conferences, to developed health policies and strategies to improve women's health, particularly with respect to primary healthcare to reduce maternal mortality ratio especially in developing countries like Nigeria (WHO, 2008). Nigeria, consequently formulated and implemented several health policies, beginning with 1988 health policy to 2001 health on reproductive health, aimed at improving its health care system but without much success, and this necessitated the introduction of the 2004 Revised National Health Policy (FMH, 2004). The study assessed the effects of the implementation of the policy fourteen years after its implementation towards the reduction of maternal mortality ratio at the Katsina state General Hospital Nigeria. The policy implementation was assessed by looking at the influence of the following factors during the implementation period - government support in resources allocation, provision of health infrastructure, effects of socio-economic factors in healthcare access, and role of advocacy groups in healthcare delivery (MoHFW, 1983; MoHFW, 2002 and The National Health Bill, 2009).

MATERIALS AND METHODS

The methodology used by the study was mixed research method, which allowed for collection of data from 100 pregnant women and 2 health officials of the General Hospital Katsina. The basis of selecting Katsina state, is because the state is among those with the highest MMR in Nigeria. The hospital was also selected because is the largest and the oldest hospital in the state, where patients are referred from several primary healthcare hospitals in the state. The data for quantitative analysis was collected through questionnaires which were distributed to pregnant women and analysed using Statistical package for social sciences (SPSS). While, data for qualitative analysis was collected using an in-depth interview with hospitals' officials and analysed using narrations.

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Concept of Maternal Mortality

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 (WHO, 2007). In addition, maternal mortality has been defined as death of women during pregnancy and or within 42days after termination of pregnancy (Hogan et al. 2008).

Maternal mortality ratio, on the other hand is 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 had the highest ratios of 403 maternal deaths, while the developed countries had the lowest ratios of 27 maternal deaths. The World Health Organization (1995), 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, 1995).

The highest maternal mortality levels are found in parts of India, and sub-Saharan Africa, while the lowest level occurs in northern Europe with some parts of developed countries of the world (less than 4 per 100,000 births in Finland (Nimi Briggs, et al. 2008). Similarly, another study by Tinker, et al. (2002), indicated that maternal mortality ratio also varies between regions of the world for example it was reported that in Africa MMR is1 in 19, while in Asia the MMR is 1 in 132, Latin America has an MMR of 1 in 188 and while in developed countries the MMR is 1 in 2,976 and in northern Europe, the risk is as low as 1 in 4000.

Nigeria, with a population of over 80.2 million women as at 2006 census and that about 49% representing 54 million women lived in rural areas, is one of the country in sub- Saharan Africa with the highest records of maternal mortality ratio (Olubunmi, et al. 2008; Gender Nigeria Report, 2012; Abdulraheem, et al. 2012, Aneikwu, 2005; Agnihotri, 2000; Arrow, 2005; WHO, 2005). However, despite its efforts to tackle the twin problems through the formulation and implementation of various health policies, it was estimated that about 545,000 to 600,000 women died annually due to pregnancy related causes in Nigeria. This constitutes about 10% world's maternal deaths births (Nursing World Nigeria, 2013 and WHO, 2010)).

Maternal mortality, is caused by both direct factors and indirect factors. The direct factors include obstetrical complications such as hemorrhages, infections, abortions performed by unqualified health personnel, eclampsia, and prolonged labor. While, the indirect factors of maternal mortality include: diseases and infections such as malaria, HIV/AIDS, hepatitis, and anemia (Osungbade et al. 2008; Garenne 1997 and Callister, 2010). Similarly, WHO, (2008), reported that 80% of maternal death in the world, are caused by factors such as severe bleeding, infections, eclampsia, and prolonged labor. Other factors responsible for maternal death include factors such as medical factors, health factors, reproductive factors, unwanted pregnancy, and socio-economic factors (Mojekwu, 2012).

NIGERIAN'S HEALTH SYSTEM AND ITS PERFORMANCE

Nigeria's health care services are delivered through a complex, integrated, and decentralized health system under the control of the three tiers of governments – federal, state, and local government (FMH, 2004). Based on the integrated health care systems, the federal government is responsible for co-ordination and implementation of national health policies. It also, supervises health activities in the 36 states of the federation and the federal capital territory, Abuja, as well as the 774 local government areas. It is also responsible for providing tertiary health care through the teaching hospitals and federal medical centers established across the country. The state government on the other hand is responsible for providing secondary health care services through the state hospitals and comprehensive health centers. The local government is responsible for providing primary health care services through primary health care centers, established across the local government headquarters and some major towns and villages. This arrangement requires

some measure of cooperation and coordination between the three tiers of governments and other agencies. Unfortunately, this arrangement often results in duplication and overlap of responsibilities, conflict, and waste (World Bank, 2010). Other health service providers include, private and non-profit, as well as community-based health organizations also provides health care services in Nigeria (Olakunde, 2012; Adie, et al. 2014).

Health care system in Nigeria is financed through a combination of sources – revenue collected from tax payers, contribution from donor agencies such as WHO, UNICEF and USAID user fees charged patients, and National health insurance scheme which was established in 2005 by Decree 35 `of 1999 (WHO, 2009). In Nigeria, the federal government provides over 90% of the funds used by health system, while the states and local governments provide the 10%. The federal government allows the state government and local government, a lot of discretion in the way they managed and disbursed the allocated funds from the federal government, under the integrated healthcare system (Scott, 2010). However, the level of funding provided by the three tiers of government to the health sector over the last three decades or so, have been inadequate and far below the United Nations recommended figure of 15% of national annual budget of UN member countries (Gender Nigeria Report, 2012).

But, it must be pointed out that Advocacy groups have continued to provide financial supports to poor developing countries like Nigeria to improve their health systems because of their inability to strengthen their health systems due to poor funding. For example, it was reported, that the Global Fund for AIDS, Tuberculosis, and Malaria (Global Fund), Bill and Melinda Gates Foundation initiatives had contributed $48 billion to research, care, prevention, and treatment of HIV within five years in developing countries including Nigeria (The Global Health Regime, 2013). Similarly, a study conducted in Nigeria also revealed that NGOs and other international donor organizations had made significant financial contributions of $ USD 32,479 Million and $ USD 45,477,907.00 in 2007 and 2008 respectively towards converting HIV/AIDs in Nigeria (Okara, et al. 2013).

Various criteria are used to evaluate a country's healthcare system to determine its efficiency and effectiveness with regards to healthcare services delivery. Some of these criteria include goals achievements, distribution coverage of the health services, quality of the services provided and then equity demonstrated when delivering the services to the citizen (Tandon, et al. 2010). However, the perfor-

mance of the Nigerian healthcare system has been low due to several policy implementation problems. Some of these problems include untimely disbursement of funds, limited institutional capacity, corruption, and unstable political and economic environment (Adinma, 2010). Other factors which affected the performance of the Nigerian health system performance was its low coverage of beneficiaries, despite the introduction of national health insurance scheme (NHIS) in 1999. This was because as at the year 2012, the scheme achieved only about 3% coverage of the Nigerian population (i.e. only five million people) cover aged with mixed results, insufficient health staff, inability of local governments to provide the primary health care with necessary equipment and drugs, socio-cultural and socio-economic factors, which hindered access health care particularly in rural areas, where majority of the population live on an average earning of ratio 1.90 dollar per day (Hongora, et al. 2013 and Asuzu, 2004). These were some of the reasons that necessitated the introduction of the 2004 Nigeria's health policy.

According to Abdulraheem, et al. (2012); FMH, (2004); and Adeyemo, (2005), the main clause of the 2004 National Health Policy is to invigorate and improve the Nigerian health system to provide effective, efficient, quality, accessible and affordable health services by achieving the following health targets: to decrease by 66%, from 1990 to 2015, the under-5 mortality rate; to decrease by 66%, from 1990 to 2015 maternal mortality rate; to cut down by 2015 and reverse the spread of HIV/AIDs; to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

THEORETICAL FRAMEWORK

The research employed the theoretical framework of Sabatier and Mazmanian (1980) and Hardee et al. (2004). This is in view of their relevance to the research topic and since similar past studies on policy implementation in developing countries found it to be more relevant, as this framework also provided certain factors which could affect the outcomes of implementation process of a policy. These factors include government political support, availability of resources (finance and personnel), availability of health infrastructure, role of advocacy groups.

DATA COLLECTION AND ANALYSIS

Section A: Responses of Pregnant Women

Demographic backgrounds of the Respondents

Table 1

Age of Respondents'

Age	Frequency	Percentage
15 – 25	43	43
26 – 35	34	34
36 – 45	15	15
46 – 55	8	8
Total (N)	**100**	**100**

From table above, 43 of the respondents representing 43% were within the ages of 15-25 years, while 34 of the respondents or 34% were between the ages 26-35years. Similarly, 15 of the respondents or 15% were between the ages of 36-45yearrs. However, 8 of the respondents or 8% were between the ages of 46-55years. This shows that majority of the women respondents were within the ages of 15 – 35years, which constitutes the reproductive age of most women at least in sub-Saharan African countries like Nigeria.

Table 2

Effects of Insufficient Funding on Healthcare Delivery

Category	Frequency	Percentage
Strongly Disa-greed	0	0
Undecided	6	6
Disagreed	2	2
Agreed	31	31
Strongly Agree	61	61
Total (N)	**100**	**100.0**

From table above, majority of the respondents (i.e. 61 or 61% and 31 or 31% of the respondents), agreed and strongly agreed respectively that insufficient funding of the health sector by the government, still constitutes a major hindrance affecting access to health care system by pregnant women. While, 2 of the respondents

which represents (i.e. 2%) disagreed with the statement by saying that the government is doing its best with regarding funding of the health sector. In the same vein, the least respondents i.e. 6 or 6% were undecided and 0 or 0% of the respondents strongly disagreed.

Table 3

Effects of Insufficient Infrastructure and personnel on Healthcare Delivery

Category	**Frequency**	**Percentage**
Strongly Disagreed	1	1
Undecided	3	3
Disagree	0	0
Agree	34	34
Strongly Agree	62	62
Total (N)	**100**	**100**

From table above, majority of the respondents (i.e. 62 or 62 % and 34 or 34%) strongly agreed and agreed respectively that insufficient health infrastructure and personnel affected the realization of the goals of 2004 revised national health policy, particularly with regards to reduction of MMR. Furthermore, none of the respondents representing disagreed that insufficient infrastructure and personnel affected healthcare delivery with regards to MMR reduction. While, 3 or 3% of the respondents were undecided and 1 or 1% of the respondents strongly disagreed respectively.

Table 4

Effects of Socio-economic factors on Healthcare Access

Category	**Frequency**	**Percentage**
Strongly Disagreed	4	4
Undecided	6	6
Disagree	17	17
Agree	48	48
Strongly Agree	25	25
Total (N)	**100**	**100**

Table above, indicates that majority of the respondents (i.e. 48 or 48% and 25 or 25%) agreed and strongly agreed respectively that socio-economic factors particularly income of the pregnant women affected their access to healthcare. While,

17 or 17% and 4 or 4% of the respondents disagreed, and strongly disagreed respectively, about the effects of socio-economic factors on access to healthcare. However, 6 or 6% of the respondents were undecided.

Table 5
Effects of Non-Governmental Organization on Healthcare Delivery

Category	Frequency	Percentage
Strongly Disagreed	11	11
Undecided	6	6
Disagree	7	7
Agree	49	49
Strongly Agree	27	27
Total (N)	**100**	**100**

From table above, indicates that majority of the respondents (i.e. 27 or 27% and 49 or 49%) 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 injectable. However, 6 or 6% were undecided while 11 or 11% of the respondents strongly disagreed with the statement, while 7 or 7% disagreed with the statement.

Table 6 Recommendations: Government to Equip and Collaborate with NGOs in Areas of Health Infrastructure, Personnel, and Drugs

Category	Frequency	Percentage
Strongly Disagreed	0	0
Undecided	2	2
Disagree	0	0
Agree	39	39
Strongly Agree	59	59
Total (N)	**100**	**100**

Table above, indicates that majority of the respondents (i.e. 59 or 59% and 39 or 39%) strongly agreed and agreed respectively that Government should equipped

its hospitals with Health Infrastructure, Personnel, and Drugs to meet the health needs of its citizens particularly for pregnant women in view of their vulnerability and weak socio-economic status. While, none of the respondents disagreed and strongly disagreed respectively, about the importance of equipped hospitals in improvement of healthcare delivery particularly with regards to pregnant women. Similarly, 2 or 2% of the respondents were undecided.

Section B: In-depth interviews with medical director (MD), and chief nursing sister (CNS), of the hospital.

1. Effects of health infrastructure and personnel on healthcare delivery?

The first respondent said that:

> *"Despite the establishment of hospitals in the 34 Local Government Areas of the state by the state Government, these hospitals are unfortunately not fully equipped to meet the needs of the ever-growing population of pregnant women. From our medical records, you can see that in the last five years a total of 15,972 pregnant women delivered, while only 269 died in the hospital, thus representing maternal mortality rates of about 1.7%. We may have not reached the target of the policy with regards to MMR reduction, but the figures are encouraging signs that if our hospitals are equipped the mortality rate would have been lower".* (MD)

While the second respondent said that:

> *"There are many government hospitals in the state, but good healthcare delivery has remained a mirage because the hospitals are not equipped with even basic things like regular power and water supply, sufficient health personnel etc.".* (CNS)

2. Effects of Socio-Economic Factors on access to healthcare?

The first respondent said that:

> *"Majority of the pregnant women that frequent this hospital are poor and this affect their ability to fully access healthcare, as many of them cannot pay for drugs, injectable, and surgery where necessary because they are poor, illiterate, unemployed and from rural areas. Most of them rely on their husbands for money".* (MD)

The second respondent said that:

"Pregnant women only enjoy free consultation and few basic cheap drugs supplied by the government, but they have to pay for other medical services and expensive drugs. Most of them cannot afford to pay for expensive drugs and other services related to surgery in view of their weak socio-economic status. This is a hinderance to healthcare access by most of them". (CNS)

3. NGOs Supporting Role in MMR Reduction

The first respondents said that:

"The state government has encouraged collaboration with NGOs in many areas like supply of drugs and blood, sensitization of members of the public, training of medical staff etc., because it cannot shoulder healthcare responsibilities alone". (MD)

The second respondents added that:

"They have been very helpful in many areas. We thank them for their support". (CNS)

4. Recommendations for Improving Healthcare Delivery

The first respondents said that:

"Government should equip its hospitals with adequate health infrastructure, personnel, drugs and injectables to carter for its citizens especially pregnant women, as a way of reducing maternal mortality ratio. It should also provide adequate funding to the hospital". (MD_1)

The second respondent added that:

"Recruitment of more health personnel and improving expanding infrastructure would go a long way to make our hospital deliver quality health services". (CNS)

DISCUSSIONS OF FINDINGS

The discussions of the findings centered around four factors, as they effect the implementation of the 2004 Revised National Health policy towards the reduction

of maternal mortality ratio at the Katsina state General Hospital Nigeria: effects of funding, effects of health infrastructure and personnel, effects of socio-economic factors in healthcare access, and effects of advocacy groups.

With regards to the funding of the hospital, majority of respondents (both the pregnant women and the hospital officials), agreed and strongly agreed that there was insufficient funding of the hospital, which appeared to be lower than the United Nation bench mark of 15% national budget, required to be allocated to health by member states. This really affected the implementation of the policy, with regards to achieving its objectives of reducing MMR by 66% at the end of 2015. Even though there was a marginal reduction of number of pregnancy related deaths in the states, the MMR was still higher than World Health Organization (WHO), recommended figure, this was because in the last five years, the hospital recorded 269 MMR per 15,972 deliveries, which translate to 1 death per 59 deliveries. This is consisted with so many sociological studies, which reported in adequate funding in most developing nations of the world (Strasser 2003; Ademilluyi et al. 2009; Berman et al. 2011; Christoph et al. 2014).

The effects of health infrastructure, personnel, and drugs, as reported by majority of the women respondents – 34% and 62% agreed and strongly agreed respectively also affected the implementation of the policy. This view was also shared by the hospital officials interviewed. Several past studies reported on the effects of insufficient infrastructure, personnel, and drugs in improvement of healthcare delivery in many developing countries like Uganda, Kenya, sub-Saharan African countries, Pakistan; Nigeria; Tanzania Burnham et al. (2004); Emmanuel (2015); National Population commission, (2008) and World Bank (2010); Bhutta et al (2011); Joseph et al. (2012); Emmanuel (2015); Galadanci et al. (2011), Abdulraheem, (2012), Christoph et al. (2014); Berman et al. (2011), Christoph et al. (2014), and Fatuma et al. (2013).

Majority of both women respondents and the hospital officials, accepted that socio-economic factors such as lack income and education in accessing healthcare services by pregnant women, especially in developing countries (like Nigeria is quite alarming as majority of the population lives below the poverty line), was seriously affecting healthcare access. The findings of this study had been supported by findings of similar studies, carried out in Uganda by Nabyonga-Orem et al. (2008), who reported the non-realisation of Uganda's health policy objectives, because of introduction of user fee, which led to decline in access to health

care services. World Bank (1997), and Dan Kaseje (2006), also reported that estimated that 54% of the total population of Sub-Saharan African lives in absolute poverty, which also affected their access to health care services, thus leading to increase in the levels of maternal, child, and infant mortality as well as low rates of immunization, especially in rural areas of Africa's communities. Similarly, a study conducted in Pakistan reported that poverty, illiteracy, and low-income level of women had contributed significantly to their low patronage of health care facilities, thus resulting increase of maternal mortality and other diseases Green et al. (2011). Furthermore, Poureslami et al. (2004), in research conducted of women living along the borders of Afghanistan, Iran and Pakistan, found that women have high disease burden and maternal mortality because of lack of income, education, and socio-cultural practices.

The findings of the study also indicated that majority of the respondents (i.e. both the pregnant women and the hospital officials), accepted the fact that, Advocacy Groups and NGOs are making positive contributions towards improvement of healthcare delivery in developing countries. Their contributions in the fight of diseases such as HIV/AIDS, tuberculosis, ringworms, reduction in maternal mortality and obstetric fistulae by way of sensitization, training of health personnel, supply of drugs/injectable, hospital equipment etc., have been complimenting governments effort in developing countries including Nigeria as reported by several studies (Kullima et al. 2009, Ajaero, 2005, Daily Trust Newspaper, 2015, and UNFPA, 1999).

RECOMMENDATIONS

To fully achieve the goal of MMR reduction in developing countries including Nigeria as required by UN and WHO, the following recommendations should be given careful consideration by policy makers, health professionals and other stakeholders concerned with improving reproductive healthcare.

There is the need for the state government to demonstrate greater government political support by increasing the annual budgetary spending allocated to the health sector, which would allow for recruitment of more health personnel, particularly gynecologist doctors and the nurses/midwives, to enhance effective service delivery, thus eliminating or grossly reducing long hours, which pregnant women spent before they are attended to. It would also allow for provision of more health infrastructure, drugs and injectable.

Since, socio-economic factors, appear to have some effects on healthcare access by the pregnant women as most of them are poor, there is need for the Katsina state government to strengthen the existing collaborative relationship between it and advocacy groups particularly NGOs, both foreign and local that have made giant achievements in improving healthcare access.

CONCLUSION

It is quite clear that despite several decades of the implementation of various health policies including the 2004 Revised National Health Policy at General Hospital, Katsina state, Nigeria, MMR has not dropped to the desired level envisaged by the Government. Factors had largely affected the implementation of the policy such as insufficient funding of the health sector, insufficient health personnel, effects of socio-economic factors. However, it was gratifying to note the positive contributions of the NGOs towards improving healthcare access by the pregnant women and indeed all other people with health challenges in developing countries like Nigeria. Their contributions have indeed complimented Government efforts, and more of it, is needed as Government of developing nations lack resources and political will to allocate 15% of their national budgets to their health sectors as required by the UN.

REFERENCES

Abdulraheem, I. S., Oladipo, A.R, & Amodu, M. O. (2012). Primary Health Care Services in Nigeria: Critical Issues and Strategies for Enhancing the Use by Rural Communities *Journal of Public Health and Epidemiology*, *4*(1), 5–13.

Adeyemo, D.O. (2005). Local Government and Health Care Delivery in Nigeria: *A Case Study J Hum Ecol. (18)*: 149-160.

Adinma, E.D., Adinma, B.J. (2010). Community Based Healthcare Financing: An Untapped Option to a More Effective Healthcare Funding in Nigeria. *Niger Med J. 2010; 51*(3): 95-100

Agnihotri, S. B. (2000). 'Declining Infant and Child Mortality in India: How do girl children fare? *Economic and Political Weekly 36*(3) 228-33

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

Arrow, (2005). ICPD Ten Years on: *Monitoring on sexual and Reproductive Health and Rights in Asia* Retrieved from

http://www.sexogsamfund.dk/Files/Filer/Sex%20og%20Samfund/Diverse/AR-ROW_ICPD_Ten_Years_On_FINAL.pdf

Asuzu, M. C. (2004). The Necessity for a Health Systems Reform in Nigeria. *Journal of Community Medicine and Primary Health Care 16(1):1-3*

Berman, P.; Pullos, S., Smith, A.L. & Bradley, E.H. (2011). Improving the Delivery of Health Sources. *A Guide to Choosing Strategies* Retrieved from http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/ImprovingDeliveryofHealthServicesFINAL.pdf

Bhutta, Z. A., Soofi, S., Cousens, S., Mohammad, S., Memon, Z. A., Ali, I. ... & Martines, J. (2011). Improvement of Perinatal and Newborn Care in Rural Pakistan through Community-based Strategies: A Cluster-randomised Effectiveness Trial. *The Lancet*, *377*(9763), 403-412.

Burnham, G. M., Pariyo, G., Galiwango, E., & Wabwire-Mangen, F. (2004). Discontinuation of Cost Sharing in Uganda. *Bulletin of the World Health Organization*, *82*(3), 187-195.

Callister, l.C. & Edwards, J.E. (2010). *Achieving Millennium Development Goal-5, the Improvement of Maternal Health 39*(5), 590-8; quiz 598-9 Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20673318

Christoph. A., et al. (2014). *The Workforce for Health in a Globalized Context - global Shortages and International Migration*, 7:23611 Retrieved from http://www.globalhealthaction.net/index.php/gha/article/view/23611

Daily Trust Newspapers, (2015). Available at www.dailytrust.com.ng

Dan Kaseje, (2006). Healthcare in Africa: Challenges, Opportunities, and an Emerging Model for Improvement. Presented at the Woodrow Wilson International Center for Scholars

Emmanuel Wekesa Wamalwa (2015). Implementation Challenges of Free Maternity Services Policy in Kenya: The Health Workers' Perspective. *The Pan African Medical Journal 22:375* doi: 10:11604/pamj.2015.22.375.6708

Fatuma, M; Joanna, A. S; Guy, H; Kaspor, W; Confad, M; Kizito, - shirima; Hassan, M Marcel, T; and David S. (2013). *Human Resources for Health Care Delivery in Tanzania: A Multifaceted Problem. 10:3* Retrieved from

Galadanci, H.S.; Idris, S.A.; Sadauki, H.M.; Yakasai, I. A. (2010). Programs and Policies for Reducing Maternal Mortality in Kano State, Nigeria: *A Review. 14*(3): 31

Garenne, M., Mbaye, K., Bah, M. D. & Dakar Correa, P. (1997). Risk Factors for Maternal Mortality: A Case Control Study in Hospitals (Senegal) *Reproductive Health1 (1), 14-24*

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

Green, A., Ali, B., Naem, A., Vassal, A. (2011). Using Costing as A District Planning and Management Tool in Baluchistan, Pakistan. *Health Policy and Planning 16(*2); 180-186

Hardee, K.; Feranil, I.; Boezwinkle, J.; Clark, B. (2004). The Policy Circle: *A Framework for Analyzing Components of Family, Reproductive Health, Maternal Health and HIV/AIDS Policies.* Retrieved from http://www.policyproject.com/pubs/workingpapers/wps-11.pdf

Hogan, et al. (2008). Maternal Mortality for 181 Countries, 1980- 2008: A Systematic Analysis of Progress towards Millennium Development Goals. *Lancet 375(9726) 1609-23*.

Joseph, N.M. & Uche, I. (2012). Maternal Mortality in Nigeria: Examination of Intervention Methods. *International Journal of Humanities and social science.2* (20)

Kullima, A. A., Kawuwa, M. B., Audu, B. M., Geidam, A. D., & Mairiga, A. G. (2009). Trends in Maternal Mortality in a Tertiary Institution in Northern Nigeria, *Annals of African Medicine, 8*(4)

MoHFW, (1983). Delhi: Ministry of Health and Family Welfare, Government of India; *National Health Policy. [PubMed]*

MoHFW, (2002). Delhi: *Ministry of Health and Family Welfare*, Government of India National Health Policy.

Mojekwu, J. N. (2012). Maternal Mortality in Nigeria: Examination of Intervention Method, *International Journal of Humanities and Social Science 2(*20) Retrieved from http://www.ijhssnet.com/journals/Vol_2_No_20_Special_Issue_October_2012/13.pdf

Nabyonga-Orem J, Karamagi H, Atuyambe L, Bagenda F, Okuonzi S & Walker O. (2008). Maintaining Quality of Health Services after Abolition of User Fees: A Uganda Case Study. BMC Health Serv Res. 2008; 8:102.PubMed | Google Scholar

National Population Commission (NPC) and ICF Macro, (2008): Nigeria Demographic and Health Survey 2008: Key Findings. Calverton, Maryland, USA: Npc and Icf Macro, Retrieved from http://www.dhsprogram.com/pubs/pdf/FR222/FR222.pdf

Nimi, B. (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/

Nursing World Nigeria, (2013). Katsina: Providing Succor to VVF Patients Retrieved from *http://www.nursingworldnigeria.com/2013/01/katsina-providing-succour-to-vvf-patients*

Okara, J.M., Umezulike, A.C., Onah, H. E. & Chukwuali, (2013). Maternal Mortality at the University of Nigeria Teaching Hospital Enugu before and after Kenya. *AfrJReprodHealth5* (2):907

Olakunde, O.B. (2012). Public Health Care Financing in Nigeria: Which Way Forward? *AnnNigerianMed6* (1):410

Olubunmi, I. & Yetunde, A. (2008). Gender Dimensions of Agriculture, Poverty, Nutrition and Food Security in Nigeria: *Nigeria Strategy Support Program (NSSP)* Background Paper. Retrieved from http://www.resakss.org/sites/default/files/blog/2011/10/gender-dimensions-paper_nigeria_nssp.pdf

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*

Phillip N. (2012). *Improving Maternal Mortality and Other Aspects of Women's Health: The United States' Global Role* Retrieved from http://csis.org/files/publication/121003_Nieburg_MaternalMortality_Web.pdf

Poureslami, I. M., MacLean, D. R., Spiegel, J., & Yassi, A. (2004). Sociocultural, Environmental, and Health Challenges Facing Women and Children Living Near the Borders Between Afghanistan, Iran, and Pakistan (AIP region). *Medscape General Medicine, 6*(3).

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

Scott Emuakpor A. (2010). The Evolution of Health Care Systems in Nigeria: Which Way Forward in the Twenty-first Century? *Niger Med J 51*(2):53-65

Strasser, R. (2003). Health Around the World: Challenges and Solution. *Journal of Family Practice.* 20 (4):457-463.

Tandon, A., Murray, C.J.L., Lauer, J.A., Evans, D. B., (2010). *Measuring Overall Health System Performance for 191 Countries* Retrieved from http://www.who.int/healthinfo/paper30.pdf

The Global Health Regime, (2013). *Global Governance Monitor*. Retrieved from http://www.cfr.org/health/global-health-regime/p22763

The National Health Bill (2009). Ministry of Health and Family Welfare, Government of India Retrieved from http://www.prsindia.org/uploads/media/Draft_National_Bill.pdf

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

UNFPA, (1999). "*The State of World Population 1999 Six Billion: A Time for Choices*." New York: UNFPA.

WHO (2008). The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium Retrieved from https://www.aho.afro.who.int/en/ahm/issue/12/reports/ouagadougou-declaration-primary-health-care-and-health-systems-africa-achieving

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

WHO 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

WHO World Health Organization (2009). *Women and Health: Today's Evidence, Tomorrow's Agenda*. Geneva Switzerland Retrieved from http://www.who.int/gender-equity-rights/en/

WHO World Health Organization, (2012). *Trends in Maternal Mortality*: 1990-2010: WHO, UNICEF, UNFPA and The World Bank Estimates Geneva: WHO retrieved from http://whqlibdoc.who.int/publications/%202012/9789241503631_eng.pdf

WHO, (2010). World Health Statistics, WHO Library Cataloguing in Publication

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

WHO, UNICEF, UNFPA, World Bank (2005). Maternal Mortality in 2005 Retrieved from http://www.who.int/whosis/mme_2005.pdf

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

World Bank, (2010). Improving Primary Health Care Delivery in Nigeria: Evidence from Four States. Retrieved from http://dx.doi.org/10.1596/978-0-8213-8311-7

World Bank Bank (1997). *World Development Report 1997: The State in a Changing World*. Oxford University Press, Incorporated. (wih Qualtrics Card), Southern Western college