

An Assessment of Safe Motherhood Initiative in Nigeria and the Achievement of the Millennium Development Goal Number 5

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Abstract: Achieving the ambitious two-thirds reduction in maternal mortality which is the aim of the Millennium Development Goals Number 5 will require more than generating sufficient donor support and carrying out medical interventions. The process of inclusion of the safe motherhood initiative into the national policy agenda in Nigeria has been quite challenging. This study attempted to highlight the state of maternal health in Nigeria using descriptive research method. The data used were from primary and secondary sources which included interviews of ante and post-natal patients of Hajiya Gambo Sawaba General Hospital, Zaria. Findings confirmed that safe motherhood needs to become a political priority with a definite national plan of action in the form of a national policy for safe motherhood. Recommendations were proffered for the prevailing situation.

Key words: Maternal mortality, millennium development goals, safe motherhood, national health policy, maternal, Nigeria

INTRODUCTION

The World Health Organization (WHO, 2005) defines health as a state of mental, physical and social well-being. Oduote described health care as the prevention, treatment and management of illness as well as the preservation of mental and physical well-being it embraces all the goods and services offered by the medical, nursing and allied health professionals and includes preventive, curative and palliative interventions as well as other goods and services designed to promote health whether they are directed at the individual or the community.

Government have a responsibility to provide health care for the people. In normal circumstances, this should start with the development of a health policy that outlines the problem with relevant data, the expected goals and the strategies for achieving them. In the absence of such a policy, health care delivery is disorganized, disparate and influenced by political pressures.

One of the indicators of national development is health. A country that has a high proportion of her people living in poor health or has a high death rate cannot be referred to as a developed country. According to Nigeria's National Population Census figures, the total population is 140,033,542 (NPCN, 2006). The female population accounts for approximately half of the total population at 68,293,683. This means that any health condition which affects either the generality of a nation's

population or that which affects half of the total population should in effect, constitute a national concern. This point highlighted thus that the importance of a healthy female population cannot be overemphasized in any discourse of women's contribution to the development of this nation for it is when women are healthy that they can fulfill their reproductive and productive roles most effectively (Kisekka, 1992). Rathgeber (1993) on why we must look at the health of women separate from men stated:

Women have special health problems that men do not experience. Women are more vulnerable to certain conditions than are men-women's health directly affects child survival chances and women's needs are often neglected if not specifically identified

Dawitt stated:

Harmful cultural practices perpetuated on women and girls particularly during pregnancy, certain birthing practices result in mitigation of their health or their quality of life

The mitigation of the health on women and girls over the years has manifested in the high incidence of maternal mortality. The World Bank Report emphasized that:

Health, a basic human right that is vital to sustainable development, eludes the majority of women about half a million women die every year from the complications of pregnancy and

child birth. Most of these deaths are preventable with simple technologies that have been available for decades. Maternal mortality ratios (maternal deaths per 100,000 live births) are on average 30 times higher in developing countries than in high-income countries

The United Nations Fund for Population Activities (UNFPA) has also reported that every minute, another woman dies in childbirth. Every minute, the loss of a mother shatters a family and threatens the well-being of surviving children. For every woman that dies 20 or more experience serious complications. It was in the light of this appalling situation that the International Conference on Population and Development called the attention of the world to the magnitude of the problem of maternal mortality and the necessity for its reduction. The Millennium summit of the United Nations (UN) also adopted a set of 8 goals (MDGs) to be achieved by the year 2015. The number 5 MDG is improved maternal mortality. The target is to reduce by three-quarters maternal mortality ratio.

About 75% reduction in maternal mortality between 1999 and 2015 was agreed to by the United Nations member states in their poverty alleviation objectives. The National Economic Empowerment and Development strategy adopted by the immediate past administration in Nigeria also acceded to this reduction of maternal mortality (NEEDS, 2004). It was in a bid to address maternal mortality reduction that the safe motherhood initiative was launched at a global level in 1987.

Although, Nigeria accounts for 2% of the world's population, she contributes 10% of the world's maternal deaths (Adamu *et al.*, 2003). Each year, as many as 60,000 Nigerian women die due to pregnancy-related complications (Roberts, 2003). Globally, only India has a larger number of maternal deaths from pregnancy-related complications and that is only because it has a population 8 times that of Nigeria (Shiffman, 2007 a, b).

Nigeria adopted the safe motherhood initiative immediately it was launched in 1987 at a global conference in Nairobi, Kenya. However, the state of maternal mortality seems to be unacceptable. It is against this backdrop that this study was conducted to examine the level of success of the programme in Nigeria and to find out the challenges militating against it as it affects the achievement of the Millennium Development Goal Number 5.

The study was carried out to provide information on those factors which have contributed to the high level of maternal mortality in Nigeria. It also attempted to highlight the social, economic and political factors which it

addressed can reduce it and guarantee the achievement of the Millennium Development Goal Number 5 (MDG 5) which is to reduce by two-thirds the rate of maternal mortality by the year, 2015. The following hypotheses were formulated to guide the study:

- H₀: The achievement of the Millennium Development Goal Number 5 (MDG 5) does not depend on prioritizing reduction in maternal mortality through a national policy on safe motherhood
- H₁: The achievement of MDG 5 depends on prioritizing reduction in maternal mortality through a national policy on safe motherhood

Safe motherhood as an area of study is quite wide. It will require an extensive research which might take quite a long time to complete. The scope of this study however is Nigeria in general and Zaria local government area in particular. The constraints of time and financial resources were the major limitations of this study.

This study is significant because the problem of maternal death and its reduction is one of the United Nations Millennium Development Goals. It is a highly topical issue because what concerns the health of half the population of Nigeria is the focus of this study that is the health of the women in Nigeria.

Maternal health and in effect safe motherhood is a germane area of study in the academia especially in the arts and social sciences. It is an area into which many international Non-Governmental Organizations (NGOs) have been diverting their resources in order to combat the high rate of maternal mortality in developing countries, a situation which is considered as deplorable and unacceptable.

The study is significant because the high rate of maternal mortality in Nigeria in which as many as 60,000 women are reported to die each year due to pregnancy-related complications will be found useful in guiding other researchers who might wish to delve deeper into the area of reproductive health in particular and of health care financing as well as health policy in general.

MATERIALS AND METHODS

Descriptive research method was employed in this study. This is because the study involved mainly the description of the state of maternal mortality in Nigeria as well as what efforts had been made and should be made towards the institutionalization of safe motherhood as a national concern. The data used for the study were generated from both secondary and primary sources.

Primary sources: Primary data used were generated through personal interviews conducted at the Hajiya Gambo Sawaba General Hospital, Zaria. Also used were the hospital record of antenatal attendance, delivery and maternal deaths, all extracted from the daily maternity register of the hospital. The major hospital in the Zaria local government area which serves the indigenous Zaria population and its environs is the Hajiya Gambo Sawaba General Hospital, Kofan Gayan, Zaria. This was what informed the choice of this hospital for the study.

The management staff of the hospital such as the Medical Director, the Hospital Matron, the Matron of the Maternity Unit and the Officer-in-Charge of the Antenatal Unit were interviewed. A total of 30 antenatal clients met on a particular antenatal day were all interviewed. Also, 20 patients met in the maternity ward were interviewed for the purpose of this study.

Secondary sources: These were data extracted from national documents, journals, newspapers, television and radio broadcasts.

Background information: Maternal mortality rate is generally defined as the number of women who die per 100,000 live deliveries as a result of pregnancy-related complications. An estimated 500,000 women die each year throughout the world from complications of pregnancy and childbirth. Unfortunately, an estimated 55,000 of these deaths occur in Nigeria. The gravity of this situation can be captured as:

When a mother dies, children lose their primary caregiver, communities are denied her paid and unpaid labour and her country forego her contributions to economic and social development. A woman's death therefore is more than a personal tragedy it represents an enormous cost to her nation, her community and her family. Any social and economic investments that have been made in her life are lost. Her family loses her love, her nurturing and her productivity both inside and outside the home (<http://www.safemotherhood.org>, accessed: 3rd June, 2008)

Maternal mortality in Nigeria: Nigeria's total population is only 2% of the world's population. However, she accounts for >10% of the world's maternal deaths in childbirth (Adamu *et al.*, 2003).

Nigeria is said to have has the 2nd highest number of maternal deaths after India (Ujah, 2005). The Nigeria demographic and health survey conducted in 2003 put the statistics of maternal mortality ratio in Nigeria at between 704/100,000 and 1,500/100,000 live births depending on the

region in question. The North-West region of the country is believed to have the highest ratio. The reasons for the high average Maternal Mortality Ratio (MMR) in Nigeria are many and diverse. It is the result of interconnection of a number of demand and supply side barriers as well as some type of delays.

Supply side barriers: The supply side barriers have to do with poor quality of services. One of the major contributors to maternal mortality in Nigeria is poor maternal health services. A 1999 rating of maternal and neonatal health services from 49 developing countries where the MNPI (Maternal and Neonatal Program Effort Index) was used to indicate poor (index 0) to high quality services (index 100) revealed that Nigeria's overall capacity to provide maternal and neonatal health services is only 49 out of 100, compared to an average of 56 for all countries involved in the study.

This places Nigeria 41st among 49 countries (MNPI: 3-6 accessed 20th April in 2008). Similarly, in 2000 the WHO (World Health Organization) ranked the performance of Nigeria's health care system 187th among 191 UN member countries (Shiffman and Okonofua, 2007). A study by Ujah *et al.* (2005) revealed that ANC (Antenatal Care) seems to have a marked impact on maternal mortality in Nigeria.

The study found that booked women (those who receive ANC) have a MMR of 172/100,000 deliveries compared to a MMR of 3405 among unbooked women that do not receive antenatal care.

Demand side barriers: Women's status and financial access to care. A part from the poor quality of services a lack of access to care and a low status of women contribute to poor maternal health statistics as well. According to the Nigerian DHS >50% of women in the country experience barriers to access maternal health care such as poverty (30%), distance to health facilities (24%) and lack of transport (24%). Altogether, 10% of women do not get the permission from their families to seek health care.

The medical reasons: Adduced for the abysmal statistics on maternal mortality are as (proportions account for are figures in parenthesis): haemorrhage (26%), infections (18%), eclampsia and hypertension (17%), unsafe abortion (11%), ectopic pregnancy (5%) and others (12%) (FMH, 2003).

The problem of high maternal mortality and how to combat it were highlighted globally in 1987 when the safe motherhood initiative was launched at a conference in Nairobi, Kenya. It was immediately adopted in Nigeria as

an initiative within a general national health policy. The challenges that maternal mortality pose in different economies have been discussed by various researchers (Costello and Osvin, 2000; Adamu *et al.*, 2003; Ujah, 2005; Ujah *et al.*, 2005). Both the International Conference on Population and Development and the poverty alleviation objectives agreed to by the United Nations member states referred to as the Millennium Development Goals (MDGs) called for a 75% reduction in maternal mortality between 1990 and the year, 2015.

The question is whether this goal is achievable, how can it be achieved, what should be done to the safe motherhood initiative towards making this goal achievable?

The health policy in Nigeria can be said to be that of incrementalism. Most new programmes within the health sector have always been just a slight addition to the existing ones. Lindblom (1979) asserted that decision makers do not annually review the whole range of existing and proposed policies to identify societal goals, research benefits and cost of alternatives in achieving these goals and then make a selection on the basis of all relevant information.

But on the contrary, policy-makers generally accept the legitimacy of established programmes and agree to continue previous policies. The reason usually being limitations in financing costs of new programmes and the political challenge involved in getting new programmes or policies passed each year would be great. This could be seen as one of the reasons why the National Health Policy has remained what it is.

Health and other policy issues generally debated at various levels of government and policies that relate to public healthstandout (Hall and Land, 1975; Lee and Mills, 1982; Walt *et al.*, 2008; Gilson and Raphael, 2008; Yeh and Brandes, 2008).

Several researchers have tried to provide models which explain how and why issues get into the policy agenda that is why some issues are taken seriously by government officials when there is no apparent crisis. The Kingdon (1984) Model considers a three-stream approach which are:

Problem stream: The government officials must learn about the conditions through indicators focusing events or feedback, i.e., routine information of health statistics, a crisis feedback from field staff or patients.

The politics stream: Here is what kingdon refers to as visible and hidden participants. The visible participants are organized interests what Lindblom (1979) refers to as partisans who put a particular point of view highlight a

specific problem and use the mass media to get attention. Such participants may be both inside and outside governments. For example, new Presidents or Prime Ministers may be powerful agenda setters because the newness of their position gives them room for maneuver. Equally, an interest group with strong statistics backing their story may be an important agenda setter.

The hidden participants are the specialists the community of academics researchers consultants who work less on getting issues into the agenda. Hidden participants on the other hand may sometimes also play active parts in getting attention for problems especially in partnership with the media. For example, a researcher with interesting findings especially if they challenge current policy may leak information to the press or call press attention to an article in a scientific journal.

The policy stream: This selects from problems and politics the proposal which will become a public policy. Selecting from among the problems and the alternative policy solutions, policy makers will use a number of different criteria such as technical feasibility, congruence with existing values, anticipation of future constraints (including financial restraints), public acceptability and politicians, receptivity.

According to Kingdon the separate streams (problems, politics and policies) may each have a life of its own but there comes a time when the three streams are joined and then policy change occurs. If the three streams all meet and become coupled then a window opens and the issue is likely to be taken up seriously by policy-makers.

What causes the three streams to come together at any one point, according to Kingdon may be due to one or more reasons: individuals, media attention, a particular crisis or the dissemination of research results. Thus, participants in the policy process automatically do not proceed from identification of a problem and then seek solution for them. Alternatives may be advocated for long periods before the opportunity arises for them to be accepted.

The Kingdon (1984)'s three-stream approach was adopted for the purpose of this study. The reason is because even though a National Health Policy was formulated to provide guidelines for addressing health conditions, it has however been observed that other policies have since been formulated to address specific health conditions.

It has therefore become imperative to highlight the fact that the country needs a separate and distinct national safe motherhood policy that will serve as a guide for safe motherhood and the realization of the MDG 5. In

a review by the World Health Organization (WHO, 2003) to assess the standard of health care in Nigeria, it was revealed that only 4.2% of public health facilities in Nigeria met internationally accepted standards for Essential Obstetric Care (EOC). It was also revealed that approximately two-thirds of all Nigerian women deliver outside of health facilities and without medical skilled attendants present.

The health sector as a whole was said to be in a dismal state. All these poor maternal health indicators and the weak performance of the health system must be understood in the context of the country's long-standing problems with governance. Nigeria has a long history of military authoritarian rule which was only recently replaced by democracy, a democracy in which corruption in the political system is endemic.

Shiffman and Okonofua (2007) while applying the Kingdon Model to analyse the state of political priority given to maternal mortality in Nigeria revealed that prior to 1999, safe motherhood received some policy attention in Nigeria but was never institutionalized as a national concern.

The situation changed in that year when a policy window opened for safe motherhood because of the transition to democratic rule which subsequently led to increased activities and efforts towards its prioritization as a policy agenda.

They affirmed that a policy window for safe motherhood opened with the country's transition to civil rule in 1999. Since then, the following factors have been identified as contributing to the opening of a policy window towards the institutionalization of safe motherhood in Nigeria. Nigeria's transition to a democratic political system in 1999 created the space for social issues such as maternal mortality reduction to appear on the national agenda.

Civil society organizations have paid more attention to the problem of maternal mortality. For instance, the Society Of Gynaecology and Obstetrics in Nigeria (SOGON, 2004) now holds annual conferences at which safe motherhood receives prominence. Foreign donors have contributed substantial amounts of funds to NGOs in Nigeria towards training, advocacy, equipment and material procurement to bring about reduction in maternal mortality.

Accumulation of credible evidence concerning the high level of maternal mortality and dismal state of maternal health facilities. Researches have been carried out by credible organizations such as UNFPA, WHO, Packard Foundation and DFID just to name a few. Inclusion of maternal health in the MDGs has preferably contributed towards the prioritization of safe motherhood

by the Nigerian state. It was also included in the NEEDS document launched by a recent Former Civilian President. The renewed interest expressed by some members of the National Assembly who have begun to lead efforts to generate bills on maternal mortality reduction and reproductive health.

Increased availability of donor resources towards maternal mortality reduction. Examples include the PATHS 7 years project whose aim is to strengthen National Health Systems at the state level and which has a focal concern on safe motherhood. DFID has launched a \$100 million project >5 years period to support the efforts of the UN agencies in Nigeria to achieve the health MDGs which include maternal mortality reduction. The USAID has pledged >\$10 million to safe motherhood initiative. Others are Parkard Foundation, MacArthur Foundation and a host of others.

Challenges to the institutionalization of safe motherhood in Nigeria: The Kingdon Model itemized the necessary ingredients that must be present before a public problem can become an issue on the policy agenda and these are the problem, the politics and the policies streams. When the problem of maternal mortality is examined, it would be clear that two of the three ingredients have existed from 1999 to date.

Problem stream: In the problem stream, it could be seen that credible statistics about the deplorable state of maternal health in Nigeria have been repeatedly disseminated by credible agencies.

Politics stream: Organized interests such as the civil society organizations both local and international have worked in diverse ways to bring the problem of high maternal mortality to the attention of the citizenry at various fora.

Policy stream: It appears that the only lacking ingredient is in the policy stream. This is because it is only the policy makers who can determine whether safe motherhood programme will be technically feasible whether the necessary funds would be provided when needed and whether the public and the politicians will be receptive to the programme such that it will generate political priority for safe motherhood in Nigeria. The challenges to its prioritization are as enumerated as:

In a federal political entity such as Nigeria, it is necessary to gain the active support of state and local-level political, social and religious leaders. This has been a problem because while data on maternal mortality at the federal level have been readily available, reliable

data on maternal mortality at the state government and local government levels have not been collated thereby making it possible for sub-national officials to deny the existence of high mortality or to argue that other priorities are more pressing. There are many informal networks of individual champions for safe motherhood both in government and outside government.

However, the network remains a loose collection of individuals and organizations with a shared concern. They have not really mobilized to become a potent unified political force to push the state to action. The federal government provides minimal financial resources for maternal mortality reduction. For instance while in 2004 for the 1st time, the federal government provided a line item allocation for reproductive health, a portion of which was directed towards safe motherhood. The total amount for safe motherhood released was only about US \$800,000 hardly enough to deal with a crisis of national scope. Safe motherhood faces competition for scarce health resources with other reproductive health causes particularly HIV/AIDS.

Safe motherhood in Nigeria: The safe motherhood initiative was launched globally in Nairobi, Kenya in 1987. It was adopted in Nigeria that same year. Due a variety of factors contributing to high maternal deaths, quite a number of strategies were proposed by various workers to address maternal mortality and these include:

- Poverty reduction, education and empowerment of women within their socio-cultural context (Adamu *et al.*, 2003)
- Income generating activities for women (Shehu, 1999)
- Social mobilization and sensitization programmes to discourage early pregnancy and harmful practices (Ujah, 2005; Onah *et al.*, 2006)
- Provision of family planning and post-abortion care services, a revision of abortion laws and the promotion of women's rights (Chudi, 2003)
- Antenatal care, the prevention and treatment of sexually transmitted diseases (Ujah, 2005)
- Provision of universal access to trained delivery attendants and emergency obstetric care services (Wall, 1998)
- Improvement of quality and quantity of maternal care staff and equipment (Ujah, 2005)
- Cost reduction through government subsidy of delivery fees and health insurance (Onah *et al.*, 2006)

Besides this, the continuous monitoring and evaluation of the quality of services and advocacy for sufficient financial and political support by donors have been regarded as essential (Nigeria MDG Report in 2004).

RESULTS AND DISCUSSION

Maternal mortality in Nigeria: According to the Nigerian demographic and health survey data, maternal mortality ratio in Nigeria ranged between 704/100,000 and 1,500/100,00 live births. This high figure was further highlighted by the World Health Organization which put the average maternal mortality ratio at about 800 deaths per 100,000 live births (WHO, 2007). In a study by the Society of Obstetricians and Gynaecologists in Nigeria (SOGON), the statistics of deliveries and maternal deaths for the years 1998-2003 in Abuth, Kaduna are shown in Table 1. Similarly, the statistics of deliveries and maternal deaths at the Hajiya Gambo Sawaba General Hospital (Kofan Gayan HGSGH) for the year, 2008 are shown in Fig. 1.

From all the statistics presented, it could be seen that whether at the national level, state level or even at local government level, maternal mortality ratio is quite high. This is considering the fact of the existence of the safe motherhood initiative in Nigeria for >17 years.

All the management staff of the HGSGH stated further that even the figures of maternal deaths as presented were not a true reflection of the situation. They stated that more women died in pregnancy during labour as well as immediately after delivery than was recorded. The reason being that even when women attended antenatal clinics, some of them would not usually deliver in the hospital. Figure 2 is a chart which shows a

Table 1: Maternal mortality in Ahmadu Bello University Teaching Hospital, Kaduna, Nigeria, 1998-2003

Years	Total deliveries	Maternal deaths	MMR/100,000
1998	1572	7	445
1999	1381	9	651
2000	1582	14	885
2001	1324	12	906
2002	1576	17	1077
2003	1895	26	1373

MMR = Maternal Mortality Rate

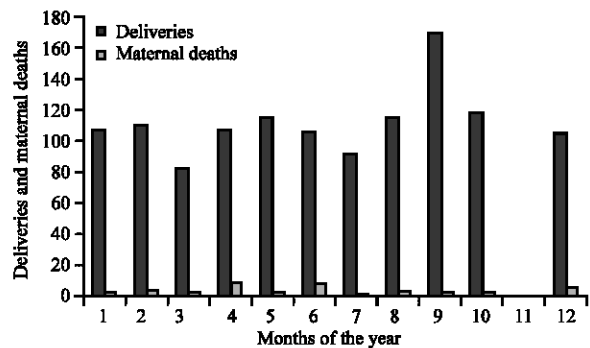


Fig. 1: Deliveries and meternal deaths at Hajiya Gambo Sawara General Hospital, Zaria, Nigeria 2008

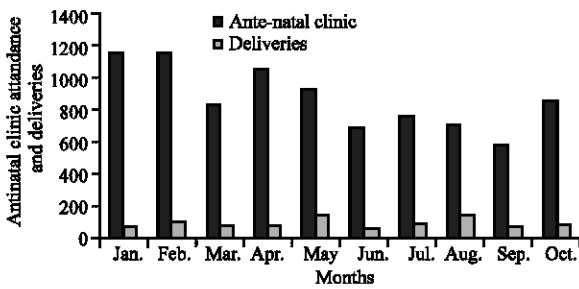


Fig. 2: Anti-natal Clinic (ANC) deliveries at Hajiji Gambo Sawara General Hospital, Zaria, Nigeria 2008

comparison of attendance at antenatal and hospital delivery at HGSGH, Zaria for the period January to October, 2008. From the chart, it could be seen that out of a total of 8,675 pregnant women who attended ANC within that period only 323 eventually returned to the hospital to deliver. Out of the 30 ANC clients interviewed to find out if they would deliver in the hospital, 8 of them (26.7%) responded that they would not.

On further investigation, the reasons given for non-hospital deliveries were mainly financial and cultural when reminded that the cost of hospital delivery had been waived by the government, 5 (16.7%) responded that they could not afford the cost of the other items which the midwives usually asked them to bring for delivery while 3 (10.0%) gave other reasons which were cultural such as the treatment of the placenta, ill treatment by hospital staff, distance of the hospital and others. In fact, 8 (26.7%) rated the behaviour of the staff as either poor or very poor. All the 30 (100%) ANC clients responded positively to knowing a pregnant woman who had died in the past 1 year.

Causes of maternal deaths: The causes of death as highlighted in the 3-delay Model show that the medical causes are usually at the 3rd level while the 1st and 2nd level are both cultural as well as financial. The four management staff that were interviewed attributed the death of mothers in the hospital to the 1st and 2nd delays that is delay in the home (inability to take decision to seek medical help) and delay in transportation (lack of money, rough terrains). The 30 (100%) ANC clients and 20 (200%) maternity patients however attributed death of pregnant women to an act of God after prolonged labour at home. From the statistics presented and analysed before, it could be seen that maternal mortality has medical as well as social and economic causes which need to be addressed using the machinery of government to provide a guide and to also provide the resources through the allocation of funds and personnel. In view of this, the alternate hypothesis which states that the achievement of

MDG 5 depends on prioritizing reduction in maternal mortality through a national policy on safe motherhood is hereby upheld.

The reason for this is that a strong political will and commitment by government is needed to provide an overall plan in the form of a national policy on safe motherhood. This will guide policy implementers on how to go about achieving the long-term as well as short-term outcomes. It will also ensure the allocation of necessary resources for it both human as well as financial.

CONCLUSION

From the statistics presented, it could be seen that even though the safe motherhood initiative had been adopted by Nigeria since 1987, maternal mortality in the country is still quite high. The major causes have also been seen to be mainly financial in terms of accessing the health care services such as ante-natal care, emergency obstetric care as well as post-natal care. This requires the attention of government to make such services free. Another dimension to the issue of access is the supply side barriers which have to do with the availability of qualified and skilled personnel at the health facilities as well as availability of drugs and equipment. These again are the responsibility of the government. The other causes which are cultural in nature could be addressed by government through a system of advocacy and awareness creation.

RECOMMENDATIONS

The United Nations had stipulated that for member nations to be able to combat poverty, one of the indicators is a reduction in the level of maternal deaths by two-thirds or 75% by the year 2015, this is the Millennium Development Goal Number 5. However, Nigeria is still very far from achieving this. It is believed that the 5 MDGs are achievable but that the most challenging one is child mortality and it has been proposed that it is only the cooperation of the three tiers of government in putting systems in place to attack the problem that will make it achievable. For sustainable development therefore the can be recommended following recommendations:

Politicians should be involved in the process. The politicians must be mobilized and sensitized to see this problem as one which should take centre stage in the process of governance. They should propose a bill such that could lead to the enactment of a national policy for safe motherhood. This would provide a coordinated road map that will attack the problem at all levels of government, something similar to what has been done to

combat HIV/AIDS by agencies of the three tiers of government. Communities and their leaders religious and traditional leaders, should be involved by tackling the cultural dimension of the problem.

Husbands should be sensitized to know and understand that the death of a wife is not just a personal loss but a loss to the entire society. Hence, the need for husbands to give all necessary support to facilitate the health of their wives. The private sector, NGOs and civil society organizations should be encouraged to cooperate with the governments as development partners.

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