HEALTH INEQUALITY AND THE EMPOWERMENT OF REPRODUCTIVE AGE WOMEN FOR DEVELOPMENT IN RIVERS STATE PRIMARY HEALTH CARE STRATEGY IN THE REDUCTION OF MATERNAL MORTALITY (2007 – 2015)

ELEM, M. (Ph.D)
Social Studies Department,
Faculty of Social Sciences,
Ignatius Ajuru University of Education Rumuolumeni,
Port Harcourt, Nigeria.
+234-8034912283

SOLOMON NYECHE (MBBS, FWACS, FMCOG)
Consultant Obstertrician/Gunaecologist,
Department of Obestetrics and Gynaecology,
University of Port Harcourt Teaching Hospital,
Nigeria.

Abstract:

This work looks at health inequality and the empowerment of women of reproductive age for development in Nigeria. The emphasis is on Rivers State government use of Primary Health Care in reducing maternal mortality from 2007 – 2015. The work observes that inequality is a common feature of modern society. The lower class which include women of reproductive age; an economically productive class, with its greater population, suffers more in terms of health challenge like maternal mortality, a preventable death. Given these, Rivers State government established primary health care, even strengthened it with other policies. This is done given the affinity between quality health care and development. In spite of the efforts, this work observes that maternal mortality is still high, pregnant women patronize Traditional Birth Attendants (TBAs) and that cultural influence provides the impetus for (TBA) patronage. In addition to this, government's approach in reducing maternal mortality and empower women of reproductive age lack systemic collaboration and neglected the use of mobile home base health team among others. Based on these, the work recommended collective political leadership; a people driven government among others. Such leadership, it is believed, can mobilize/distribute resources efficiently between and among the sectors to enable each to play their needed complementary sectoral roles which development requires. Finally, the work recommend that ruling class health should be tied to public health; therefore all ruling class medical trips abroad should be cancelled. This way, proper legislative and executive attention will be achieved.

Keywords: Health inequality, Empowerment, Women of reproductive age, Primary Health Care.

INTRODUCTION

Inequality is a common feature of capitalist society. It stems from the concentration of investible public wealth in the hands of very powerful majority (in status) but few in population. Class, a social group whose members share the same relationship to the forces of production, is derived from wealth ownership. Associated with this, is the fact that all services in modern society is considered an article of trade with money value attached to it, thus each service can be bought and sold. In this respect, your class position in the strata determines the value of social services you will enjoy. In this instance, every class has associated class behavior and associated health challenges. From this scenario, given the majority class privilege position in the stratification and their small population and wealth, their health challenge will be negligible vis-a-vis the less privilege class, given their population, minority status and wealth. That is, access to quality health care is a function of the volume or level of concentration of available investible wealth and income derived from it.

Health inequality, according to Marmort (2004) in http://www.health-inequalities-eu/health occurs along a social gradient. He further stresses that a stepwise or linear decrease in health comes with decrease in health and with decrease in social position. Health inequalities also exist globally between developed and underdeveloped nations. In which ever platform, health inequality is variation in health between social groups. In this sense, different classes manifest different health challenges given their income level. Commenting on this, Kanupriya and Chaturvedi (2015), claim that health inequality is a normative idea and is those inequalities that are judged to be unjust and unfair because they are a product of a socially deprived process.

Based on the growing global health inequality, especially its devastating effect in low income bracket in the third world countries, and most importantly its effects on women of reproductive age, World Health Organization and United Nations Children Fund (UNICEF) organized a health conference in Alma Ata in Russia in September, 1978 to address widening global health gap especially in the third world countries. The proceedings of the conference led to the emergence of Primary Health Care (PHC) as a health strategy (with maternal mortality as one of its components) to bridge the health gap between the rich and the poor especially in the third world. Maternal mortality, the death of a woman of reproductive age due to pregnancy complication is classified among preventable deaths. Given the nexus between health and development and the role of women of reproductive age in Rivers State and Nigeria development, government made PHC as the driving tool to reduce escalating health inequality especially preventable deaths like maternal mortality. Based on this, PHC has had a number of innovative reforms. The main impulse behind the use of PHC to reduce health gap is located on the role improvement in health plays in life expectancy; a robust indicator of human development. Quality health care is a basic objective of development (Ezekwu, 2014).

Statement of the problem

The role of PHC in Nigeria's health sector in the reduction of maternal mortality has been stressed by both scholars and government. For example, the 2004 Revised National Health Policy recognized PHC as the cornerstone of the nation's national health care. As a cornerstone, Acholu (2008) and Ositimehin (2009) claim that PHC is the entry point in Nigeria health system. Stressing this, Osotimehin (2009) observes that PHC is health instrument that meets the majority of the people where they live; it is a health care that is

community – owned. The deduction from the above is that Primary Health Care is a potent mechanism to reach the seemingly unreachable majority poor population to enable them to lead an economically productive social life. Evidence from Nigeria 2006 population census confirms that the rural area is predominantly dominated by the poor. In Nigeria, as is the case in other African countries, there is an absence of social infrastructure, including health-care in the rural areas. In addition to these, rural areas are a predominantly food/fibre production sector. It is typified by a higher concentration of the young and low proportion of the productive segment of the population. Sex ratio is higher with women contributing a great percentage. Given this, women play very vital role in agriculture; their primary occupation. This explains why Melletus (2010) in Elem (2015) affirms that Black Africa is the region of female farming per excellence. Melletus and Titus (2010) further stresses that rural women contribute two – thirds of all the things that is put into traditional agriculture in Africa.

Commenting further on the population structure of rural areas, Anele and Elem (2012) reveal that most rural women, in addition to high women population concentration, are in their economically active age and, thus have a high fertility level. Commenting on Nigerian women's propensity for child birth, Nigeria Demographic Health Survey (NDHS, 2008) informs that an average rural Nigerian woman has two or more children than urban woman. In addition, NDHS (2008) report stresses that urban women marry four years later than rural woman. Given this, the average number of children in the rural area ranges from 4.7 while the urban area is 6.3 (Nigeria Health Review, 2009). Rural women of this age bracket rationalize their high population or multiple pregnancy on the premise that high family size provides them the opportunity for parenting children since they cannot determine how many of their children will survive (Anele and Elem, 2012). Multiple pregnancies endanger their health, given their poverty level, which is below international poverty line. According to Federal Ministry of Health (2007) about 2,300 of children less than five years old die every year and that over one million Nigerian children will die before their fifth birth day. These figures represent about 10.5 of the global total child death.

In Nigeria, maternal mortality rate, according to WHO (2007), NDHS (2008), FMH (2004) reveals that 59,000 women die yearly as a result of pregnancy complications. NDHS (2003) in Oladipo (2009) affirmed that Nigerian women are 500 times more likely to die in child birth than her European counterpart. Oladipo (2009) equally observes that Nigeria is ranked second after India in global maternal incident rate and the worst in Africa. In a further revelation, NDHS (2008) report puts Nigeria maternal mortality ratio at 545 per 100,000. That is, in every 20 live births one maternal incident is recorded. Premium Times Newspaper (2015), quoting Akani (2014) asserts that 25% of maternal, infant deaths in sub-Sahara Africa come from Nigeria. In this respect, Akani (2014), in Premium Times informs that the risk of a woman dying as a result of pregnancy or childbirth in Nigeria is about one (1) in fifteen (15), as opposed to one in 5,000 in developed nations. Observing rural –urban differentials, FMH (2010) observes that rural area has 825 per 100,000 as opposed to 35 per 100,000 live births in the urban areas. Furthermore, Uzuigwe and Fubara (2003) in an analysis of 1225 maternal death cases which occurred due to ruptured ectopic pregnancies in the Anatomy and Pathology Department in the University of Port Harcourt Teaching Hospital (UPTH) between 1990 – 2001 inform that 71% of the cases come from rural Rivers State and that age 20 – 30 are the vulnerable group. Similarly, Ezebunwa (2003) in a study of pregnancy outcome among the Ibanis in Rivers State discovered that maternal mortality incident rate is high, and pregnancy outcome is a function of socio-cultural factors.

The impacts of maternal mortality on the development of society are enormous. As observed earlier, rural women, especially women of reproductive age constitute the backbone of Nigeria food supply even in the face of petro-dollar economy. In health, for example, most women know the medical use of some trees. In Nigeria urban economy, women dominate urban the informal sector. This sector over the years has employed more labour than other sectors. In Rivers State, women apart from shallow water fishing, process and market sea foods. This excludes women's influence on child care as they are good managers of the home. In some instances, especially single homes and where the man has lost his job, women double as bread winners.

In peace- making, women stand tall as they wield significant influence in quarrels men are unable to settle. This way, they have become peace builders. Today women take care of their parents than men. This experience informed why in Ikwerre ethnic nationality it is assumed that Wayibuekwu; meaning, women are wealth. Offor (2014) in discussing gender contributions and cultural activities in Odufia Etche, an ethnic nationality in Rivers State, clearly reveals vital complementary roles women play in cultural activities with men. These include: Marriage ceremonies; New yam festival; Death and burial; Craft making; Farming; Traditional priesthood; Palm tree harvesting; Wrestling; Chieftaincy installations. During chieftaincy installation ceremonies, women with their colorfully selected uniforms sing songs and dance; such cultural roles make the event thick. This glamour which women bring during wrestling contest is a memorable one. This informs the saying in Ikwerre land that Orta, (also called Egele) nnenwe adanna zushe orzu; meaning, any wrestler whose parent doesn't have a first daughter do not enjoy spreading popularity/fame in his wrestling feat. These roles can be truncated by maternal death each time it occurs. The core issue in this matter is that women of reproductive age are vital human resources to the development of any economy thus their loss as a result of pregnancy complication is a significant minus and can truncate development. In Nigeria, and indeed Rivers State, burial rites involve a lot financial and human resources. In some instances, some people sell their investment to meet burial responsibility.

Maternal death is often associated with considerable grief and depression since such deaths are premature deaths. A maternal death defines/determines child's survival. This is seen in respect of mother care like breast feeding and the child's social health. Adetokunbo and Herbert (2003); Oluh (2007) and Peter (2012) are of the view that breast milk is invaluable to the baby's health and survival. According to Peter (2012) breast milk contains all the proteins, calories, electrolytes, minerals, etc. that the baby needs for the four to six months of his/her life. These scholars collectively attest that breast milk protests the child against infection and common childhood diseases. For these scholars breast milk contains anti-bodies and white blood cells which work against bacteria and viruses. In addition, breast milk prevents premature babies from developing severe intestinal disorder. It fosters optimal growth of the child's immune system. Stressing this, Peter (2012) reveals that children who did not breast feed at all are 14 times more likely to die of diarrhea than the children who had exclusive breast milk. He further states that such children also are four times more likely to die of acute respiratory infection.

Stretching it the more, Peter (2012) adds that breast feeding especially the exclusive type, promotes bonding between mother and child; thus it helps in promoting psychomotor, social and emotional development. It is believed that babies who had exclusive breast feeding are more intelligent. This is because of the presence of amino acid in the milk, which helps in brain growth and development. The act of sucking of breast milk helps in the development of

the child's jaw. The relevance of breast to the child can be extended to its role in reducing the risk of childhood diabetes, obesity and heart diseases later in life.

Maternal mortality, apart from the health implications on the child's future due to maternal deprivation of the child, also has a psychological impact on the child. Ekpenyong (2004) explaining psychological theory of deviant behavior, linked deviant behavior to inadequate socialization due to maternal derivation of the child from his/her mother in early childhood. Such childhood experience, according to Ekpenyong (2004), predisposes the child to anti-social behavior at later age. A child whose mother dies early, from this understanding, is likely to become a potential criminal in the future if proper steps are not taken. In most cases the loss of women of reproductive age from birth complication adversely affects family income and increases the socio-economic burden on the man and children. These form the basis why federal and state Government made Primary Health Care a cornerstone of the nation's healthcare. This can be seen in the 2004 Revised National Health Policy; The formation of Primary Health Care Development Agency; and National Health insurance scheme among others. In Rivers State, within the years under review, so many efforts have been made to reach out to women of reproductive age in respect of child birth.

Firstly, the state runs free medical care; government has liaised with UNICEF in PHC. Through this, the state benefited about ₦975, 9001, 732 between 8/07/04 to 30/01/2012 in PHC (Rivers State Ministry of Finance, 2012). The state has established 317 PHC. In 2011 alone 60 PHC were commissioned across the 23 Local Government Areas in Rivers State. The state also recruited 460 medical doctors, 3000 nurses, 20 Pharmacists and 160 Record Officers. This excludes the mother and child hospital in the Air force base and Public – Private Partnership (PPP) approach in health. Through PPP, Millennium Development Goal (MDG) has procured and supplied equipment and furniture including Desktop Computers, printers and accessories for 66 model PHC and 15 marine ambulance boats, while Niger Delta Development Commission has built and furnished the mother and child hospital at Air force base (Rivers State Ministry of Health, 2013). In the face of these, Rivers State Ministry of Health 2008 report puts the state maternal mortality at 889 per 100,000 line birth. This report equally claims that the figure is one of the worst in the world.

THE AREA AND NATURE OF RIVERS STATE

Rivers State is located in the heart of Nigeria's Niger Delta. Its topography is plain and is netted in a web of rivers and fresh water, some of these waters are seasonal in nature. Differences in language exist among the indigenes but common attributes are seen in terms of upland and riverine. These characteristics define their common economic activity which is mainly farming and fishing respectively. The state has Port Harcourt as its capital. Rivers State is bounded in the South by the Atlantic Ocean, in the East by Akwa – Ibom, in the North by Anambra, Imo and Abia State and in the West by Bayelsa and Delta State. Rivers State has 23 Local Government Areas, out of these eight (8) is located in the water while fifteen (15) is in upland with fresh water around them.

The State has a population of 5 million persons (2006 Nigeria population Census). In all, over 70% of the area is rural with poor infrastructure which is skewed in favor of Port Harcourt and Obio/Akpor, the urban area. Presently, only few rural communities can be accessed by road especially the riverine areas. Power supply, where it exists, is epileptic. Among the inhabitants are women of reproductive age with a population of 2,525,690 (NPC, 2006). According to UNICEF (2004) work on socio-cultural contest of reproductive health

and gender issues in Rivers State in 2004, Rivers State has inadequate reproductive health facilities and such there is limited antenatal services and ignorance is rift.

The study equally reveals that Traditional Birth Attendants (TBAs) and prayer houses are patronized by pregnant women during pregnancy and child birth. In addition malnutrition and excessive work makes pregnant women suffer from anemia. This has compelled workers to engage in excessive work either in the farm or in the river. The weight of this impact negatively on these women as maternal complication which if not properly managed can result in maternal death. Similarly, male dominance in decision making and control in access to economic resources exist. All these exist because of poor education and weak economic background. Interestingly too, there exist male child preference over women. This on its own causes high risk pregnancy. In the same way early marriage exist, this invariably hinder women education and economic growth.

According to UNFPA (2004) in Elem and Worgu (2015), unwanted pregnancy exists and abortion is a strategy by both the pregnant girls and their mothers to address it. This background inform the use of PHC to address maternal mortality as health cum – development policy in Nigeria and in Rivers State. In the face of such investment in health, Onyemaheihia (2009) in Igbarase (2012) reveals that most pregnant women in Niger Delta region still patronize TBAs in birth. Igbarase further reveal that TBAs in Niger Delta region still use toxic herbs which they insert in the women vagina to terminate unwanted pregnancy. In a similar study Emejuru (2011), in a study of the factors responsible for the increased patronage of TBAs by pregnant mothers in Omopo community in Elele - Ikwerre Local government Area in Rivers State informed that most pregnant women register and attend antenatal services in PHC centres but during labor and child birth they patronize TBAs. Emerujuru's (2012) finding corroborates Chujor's (2014) finding in the attitude of pregnant mothers towards hospital delivery in Eleme Local Government in Rivers State. Chujor's work reveals that PHC centres record massive turnout of pregnant women during antenatal but record scanty patronage during delivery because the women prefer using TBAs during delivery. These scenarios indicate that government approach in addressing health inequality; empower women of reproductive age for development and reduction maternal mortality has become problematic. The more PHC is strengthened; the more pregnant women still patronize TBAs during childbirth and this leads to pregnancy complication and consequently maternal mortality where the complication is not properly handled.

X-ray of Rivers State Government use of PHC to reduce maternal mortality, bridge health inequality and empower women of reproductive age for development

Clearly PHC is an effort to address health inequality and to empower women of reproductive age to perform their development role. As a health cum development policy, State government approach lacks adequate texture to achieve reduction in maternal mortality, health inequality and empower women of reproductive age for development. In this sense systemic collaboration is priceless. The imperative in this premise is that investment in health alone without equivalent investment in critical sector like education is unscientific. For instance, family members' acceptance of PHC programme to a large extent is dependent on their level of education. This makes education and information industry a critical element in the success and failure of PHC programme. Education is empowerment, this way, the families can afford the payment for basic health services needed in the health centres like card registration. This brand of empowerment can affect effective choice making between utilization of PHC and TBA by family members, especially women of reproductive age. It is the absence of this that has strengthened the influence of socio-cultural factors during child

birth which has heightened maternal mortality. Similarly, good road network and efficient power supply is invaluable. Electric power, for example, is essential because drugs must be stored, the labor room need electric light, the computer system and other test equipment need electric light for maximum performance. A closer look at components of PHC reaffirmed the place of water supply, health education, food supply and environmental sanitation among others. For this reason systemic approach is essential. Similarly most of the rural areas, the catchment area for PHC programme, where women of reproductive age live, lacks social infrastructure. What this represents is that systemic failure is the main cause of the low success recorded in the use of PHC as a tool to address health inequality and to reduce maternal mortality in Rivers State.

Although the state has invested in Primary and Secondary School education, great energy is spent in urban areas, the non-volatile / vulnerable area. Even in this, less emphasis is placed on health education. Health education is vital because it emphasizes child survival, reproductive health and nutrition in its curriculum. An understanding of these in a compulsory primary and secondary education will provide women with early understanding of their reproductive health; even provide a platform to resist patronage of TBAs during childbirth. Beyond achieving maternal education, health education will address behavior modification to the use of PHC in the reduction of maternal mortality and in the elimination of ignorance. A combination of these in the State compulsory Primary and Secondary education will enhance woman capacity to obtain, even understand, basic health services. Such opportunity will help them make appropriate health decisions like child spacing, common signs of pregnancy complications and the urgent need to improve their nutritional status. Above all, education is empowerment, thus most homes will be able to afford the payment of basic antenatal registration and other minor test costs. This factor constitutes the driving force for underutilization of PHC by pregnant women in the state.

Similarly, since women are the major factor in PHC scheme, it is expected that soft loan and free skills acquisition programme be added to compulsory primary and secondary education. Through this, problems associated with birth payment, Card registration and transport cost to PHC, living in good sanitary environment and drinking potable water will be reduced. These, especially lack of good environment and potable water, opens the window for malnutrition, malaria and other diseases that can cause/ aggregate maternal complications.

Finally, even though a lot of PHC have been established within the period, it is observed that most PHC centres were sited outside working distance to the people/community. This has stimulated the option for TBAs who live with the people and can be accessible even if the labor starts in the night.

CONCLUSION AND RECOMMENDATIONS

The concern for health generally cannot be isolated from development. This background given the role women of reproductive age play in Nigeria economy, inform the use of PHC as a health cum development policy. Given this, Rivers State government has demonstrated its willingness to empower women of reproductive age and reduce maternal mortality by establishing and funding PHC among other instruments. However the purpose of establishing PHC is far from being achieved. This is mainly due to lack of systemic approach in the use of PHC as a tool to achieve health equality, empower women of reproductive age and reduce maternal mortality (an avoidable death common among the poor) in Rivers State. This is in addition to lack of non-inclusion of soft loan for women of reproductive age, at least given the role of income in the patronage of TBA over PHC by pregnant women.

Given these background, it is expedient that the use of home-base health care team that will consist of retired midwives, TBAs drawn from the respective communities in each of the LGAs in the state, medical doctors and medical staff from the PHC Centres, most of these should be women. The role of this team is to take stock/visit pregnant women that registered with TBAs. The beauty of this strategy is that development programme is primarily concerned with solving development challenges. The presence of retired midwives from the LGA for example, will help in eliminating communication problems associated with collecting patients' medical data. This is possible because such persons are conversant with the people's culture, especially the language. Secondly, it will eliminate the common feeling of most pregnant women that PHC staffs are children. Again, through this process, medical team will be able to track the health status of the expectant mothers (even the baby in the womb) of these women who registered with the TBAs. In addition, the approach will provide the opportunity for the medical team to get medical history of the women and their real date of delivery. This way, the team can be on ground during child delivery. Such details will help to determine emergency cases on time before delivery date. Secondly, key problems which can cause complications if left in the hands of TBAs will be eliminated. In essence, this approach provides pregnancy cases with TBAs with a touch of modern health care instead of delivery that will be exclusively performed by the TBAs.

Based on these, the following recommendations are offered; Firstly, collective political leadership - a people driven government that will drive the system. Such leadership is chosen because it is characterized by effective leadership. It is capable of mobilizing resources/distributing them between and among the sectors to facilitate their effective complimentary roles for development. In addition to this, ruling class health should be tied to the general public health care. This way both will share the same fate. In this sense, public health will be taken seriously as both privileged and underprivileged will source for their health in the same market. Through this process a robust participation in terms of legislative and executive attention and institutional collaboration in PHC will be achieved. The beauty of this is that common obstacle that will hinder the success of PHC to reduce maternal mortality and empowerment of women of reproductive age will be achieved. This way, it is expected that all ruling class medical trips abroad should be cancelled.

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