Afr. J. Med. Med. Sci. (2022) **51**(4) 255-263

Perception of healthcare workers and end-users about the implementation of the Abiye Scheme in Ondo State, Nigeria

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Abstract

Background: To upturn the poor maternal, children and neonatal health indicators in a South-west Nigerian state, the Abiye Scheme was inaugurated in 2009. This study assessed the perception of healthcare workers and end-users in Ondo State about the implementation of the four strategies proposed to actualise this scheme.

Methods: This qualitative study employed the use of 15 key informant interviews (KIIs) conducted among 15 healthcare workers and eight focus group discussions (FGDs) conducted among 72 pregnant and nursing mothers to generate essential data. The Abiye scheme strategies assessed were the establishment of a health insurance scheme; utilization of health rangers (HR); upgrade and renovation of peripheral health facilities; and establishment of mother and child hospitals. All interviews were audio-recorded, transcribed verbatim, coded, and analysed with Nvivo 10 software using framework analysis via deductive methods.

Results: The study respondents perceived the Abiye scheme as a well-conceptualized program with good intentions. Only the establishment of the mother and child hospitals strategy of the Abiye scheme was perceived to be properly implemented by our study respondents. According to the respondents, the health insurance scheme was nearly non-existent.

Conclusion: Abiye scheme is undisputedly a well-conceptualized program that has impacted positively its users. Nonetheless, the laid down strategies have not been fully implemented. To achieve maximal impact, the health rangers must be enabled to perform their duties; the health insurance component must be strengthened and properly implemented; and the peripheral health facilities should be quickly and actively co-opted into the scheme.

Keywords: *Infant mortality ratio, maternal mortality ratio, Midwives Service Scheme, Health Insurance, Abiye Scheme*

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Résumé

Contexte : Pour redresser les mauvais indicateurs de santé maternelle, infantile et néonatale dans un État du sud-ouest du Nigéria, le programme Abiye a été inauguré en 2009. Cette étude a évalué la perception des agents de santé et des utilisatrices dans l'État d'Ondo concernant la mise en œuvre des quatre stratégies proposées pour concrétiser ce programme.

Méthodes : Cette étude qualitative a employé l'utilisation de 15 entretiens avec des informateurs clés (KIIs) menés auprès de 15 agents de santé et huit discussions de groupe focus (FGDs) menées auprès de 72 femmes enceintes et mères allaitantes pour générer des données essentielles. Les stratégies du régime Abiye évaluées étaient la mise en place d'un régime d'assurance maladie ; utilisation des gardes sanitaires (HR) ; mise à niveau et rénovation des structures sanitaires périphériques ; et la création d'hôpitaux mère-enfant. Tous les entretiens ont été enregistrés audio, transcrits textuellement, codés et analysés avec le logiciel Nvivo 10 en utilisant une analyse de cadre par des méthodes déductives.

Résultats : Les répondants à l'étude ont perçu le programme Abiye comme un programme bien conceptualisé avec de bonnes intentions. Seule la mise en place de la stratégie des hôpitaux mère-enfant du programme Abiye a été perçue comme correctement mise en œuvre par les répondants de notre étude. Selon les personnes interrogées, le régime d'assurance maladie était quasiment inexistant.

Conclusion: Le programme Abiye est incontestablement un programme bien conceptualisé qui a eu un impact positif sur ses utilisatrices. Néanmoins, les stratégies définies n'ont pas été pleinement mises en œuvre. Pour obtenir un impact maximal, les gardes sanitaires doivent être en mesure d'exercer leurs fonctions ; le component assurance maladie doit être renforcé et correctement mis en œuvre ; et les structures sanitaires périphériques doivent être rapidement et activement cooptées dans le programme.

Mots clés: *Taux de mortalité infantile, taux de mortalité maternelle, Régime de services de sages-femmes, Assurance maladie, Programme Abiye*

Introduction

Reduction of child mortality and improvement of maternal health that was set at the 2000 Millennium Summit are two important Millennium Development Goals (MDGs), which are also central to the Sustainable Development Goals (SDGs) [1,2]. Despite the global progress towards achieving these two goals using verifiable indicators, regional variations persist.

Globally, the number of deaths of children under-five years of age fell from 12.6 million in 1990 to 5.3 million in 2018 [3]. However, unlike Eastern Asia and Northern Africa that have achieved 70 percent and 68 percent reductions in under-five mortality respectively, sub-Saharan Africa has achieved only a 39 percent reduction[4–6]. Statistics from Nigeria, a sub-Saharan African nation, showed that the Nigerian under-five mortality (U5M) rate dropped from 292.7 deaths per 1,000 live births in 1969 to only 119.9 deaths per 1,000 live births in 2018 [7]**.** As a result of this slow progress in the reduction of under-five mortality rate in the country, which is typical of other sub-Saharan countries, Nigeria was tagged one of the worst-hit countries as far as child mortality is concerned [8].

Maternal mortality ranges from as low as 27 maternal deaths per 100,000 live births yearly in some countries to as high as 533 maternal deaths per 100,000 live births in other countries[9]. In Nigeria, as high as 512 maternal deaths still occur in 100,000 live births, making it one of the highest rates globally [10]. Previous studies [11–13] attributed varying levels of MMR to different levels of social inequalities. These factors include the age of the mother at childbirth; maternal education; wealth status; household sanitation; availability of clean and safe water; and availability, accessibility, and affordability of health services.

As a result of the poor progress towards the reduction of the maternal and child health indices in Nigeria, several policy initiatives were established by both the Federal and State Governments of Nigeria to enhance the reduction in maternal and child mortality in the country. Notable amongst such initiatives was the Abiye Scheme initiated by the Ondo State Government.

The Abiye Scheme was a free health scheme established to improve maternal and child health (MCH) outcomes among under five and pregnant women in Ondo State using strategies that were targeted at preventing the four core phases of delay which have been documented to promote maternal deaths.[14–17] The strategies adopted to achieve this initiative were the establishment of a health insurance scheme for pregnant women and under-five children; establishment of Health Rangers (HRs), who were specially trained community health extension workers (CHEWs); upgrade and renovation of peripheral facilities in all localities within the state, ensuring they are well equipped and with adequately manned personnel trained on safe delivery practices, emergency obstetric and newborn care; and establishment of world-class Mother and Child Hospitals in the State to take care of emergencies and referrals from other lower health facilities. [18]

The Abiye scheme, which started in 2009, has gained tremendous public acceptance and popularity both locally and internationally. There is however no known documented report which has assessed its implementation by any independent researcher besides what has been reported by the government or its agents. This study, conducted by independent researchers, therefore assessed the perception of health service providers and end-users about the implementation of the strategies proposed to actualise the scheme. The outcome of the study will provide stakeholders with unbiased information on the aspects of the Abiye Scheme that worked and the aspects which did not work well and why. The study outcomes will also guide future maternal and child health programmers in developing countries on maternal and child health policy formulation and implementation.

Methods

This qualitative study was carried out in Ondo State, Nigeria using Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

Ondo state is one of the 6 south-western states in Nigeria. Its estimated population size was about 3.5--- - million, according to the 2006 census, with an approximate total area of 15,500 km^2 [17]. Prior to the Abiye Scheme, Ondo State had 513 existing peripheral health facilities comprising of 30 general hospitals (GH) and comprehensive health centres (CHC); and 483 health centres spread across the eighteen Local Government Areas (LGA) of the state. Under the Abiye Scheme, two Mother and Child Hospitals were established in two LGAs in the state.

The two existing mother and child hospitals established under the Abiye scheme in the state were automatically included in this study while four

peripheral health facilities were selected from the sampling frame of all peripheral hospitals in the state using a simple random sampling technique.

The study population for the KII comprised of two management staff from the Ondo State Hospital Management Board; the Chief Medical Directors (CMD) of selected health facilities; heads of units nominated by the CMD in the selected health facilities; and purposively selected doctors and nurses working in the selected health facilities. A total of two CMDs, 6 heads of units, and 12 health workers (comprising of doctors and nurses) were proposed to be interviewed. The interviews were however stopped as soon as saturation was observed. A key informant interview guide was used to assess the perceptions of the key informants about the conceptualization of the Abiye scheme as well as their perception of the implementation of the various strategies that were proposed to actualise the Abiye scheme. The proposed strategies for the Abiye scheme that were assessed were the establishment of a health insurance scheme; utilization of health rangers; upgrade and renovation of the peripheral health facilities; and establishment of the mother and child hospitals.

A total of eight focus group discussions were planned for field interviews and these planned eight FGDs were conducted among purposively selected pregnant women and nursing mothers, who were the major end-users of the Abiye scheme, attending the two Mother and Child Hospitals and four selected peripheral health facilities. Each FGD had between ten and twelve discussants. A focus group discussion guide was used to assess the perception of the pregnant women and nursing mothers about the implementation of the various strategies that were proposed to actualise the Abiye scheme as outlined earlier, as well as their satisfaction with the implementation of the mother and child hospitals strategy of the scheme. The six health facilities where this study was conducted, and the number of interviews conducted are shown in Table 1.

The FGDs and KIIs were conducted in both English and Yoruba languages, depending on the literacy level of the participants. In order to ensure adequacy, interview guides were translated into Yoruba and translated back by an independent translator. This was done to verify that the true message in the interviews was retained. The audios of the FGD and KII sessions were recorded after seeking permission from the interviewees and discussants. All the interviews were transcribed verbatim. Transcripts from the FGDs and KIIs were analysed with a focus on identifying recurrent, dominant and divergent opinions [19]. The data analysis was done based on a thematic approach. Nvivo 13 software was used to analyse the transcribed data. The findings were organized around themes and sub-themes.

Ethical approval for the conduct of the study was granted by the Ethical Review Committee of the Ondo State Hospital Management Board, Akure, Ondo State with reference number G8061/94. The data collection process was performed according to standard ethical guidelines. Written informed consent was obtained from all discussants and interviewees before discussions and interviews. Non-educated participants were offered the opportunity to thumbprint to signify consent. Local but trained translators (with a minimum of a higher national diploma degree certificate) were utilised to facilitate a proper understanding of the aims and objectives of the study among non-educated participants. The data collection procedures posed no physical harm to the participants. Psychological trauma was observed in a few cases particularly participants with poor obstetric histories that were asked sensitive questions. Such patients were immediately referred for psychotherapy. Confidentiality of all participants was guaranteed as all statements made were anonymized and protected by ensuring that no individual identifiers existed in the reports. All information provided by the

Table 1: Distribution of selected study sites by number of KIIs and FGDs conducted

Study sites	Number of KIIs conducted	Number of FGDs conducted
Mother & Child Hospital, Akure, Akure South LGA	4	2
Mother & Child Hospital, Ondo, Ondo West LGA	3	2
General Hospital, Idanre, Idanre LGA	2	1
General Hospital, Ile-Oluji, Ile Oluji/Okeigbo LGA:	2	1
Basic Health Centre, Arigidi Akoko, Akoko East LGA	2	1
Comprehensive Health Centre, Iju, Akure North	2	1
Total	15	8

participants were encrypted and kept in safe custody by the lead researcher.

Results

Overall, two management staff, one Chief Medical Director, 6 medical doctors and 6 nurses participated in the KIIs. A total of seventy-two nursing mothers and pregnant women participated in the FGDs.

Conceptualization of the Abiye Scheme

The majority of the key informants believed that the programme was well conceived considering the position of the state among other states of the federation as far as maternal and child health indices were concerned. They attested to the fact that the Abiye scheme was implemented at the right time because the majority of maternal mortality among pregnant women occurred as a result of delays in seeking health services.

A key informant noted:

"Before this administration……, of every ten women that die as a result of pregnancy in Nigeria, Ondo state accounted for the highest figure in the South West. Abiye is invented to take services closer to people and eliminate delays by providing prompt, critical and adequate intervention where necessary" (A female top management staff, KII).

A chief medical director of one of the hospitals noted:

"Most deaths occur because of delays in seeking health services. Abiye was brought about to reduce maternal preventable deaths and also minimize children mortality" (A male CMD, KII).

A medical doctor in one of the health facilities said:

"*The scheme was a mere re-branding whereby such programme had always existed from government to government but considering the poor utilization of antenatal care services in the state prior to 2009 and been worst among committee of states in the South West region in terms of maternal health indicators as documented by the two most recent NDHS, Abiye scheme was much needed as of the time it was initiated. (A male doctor, KII)*

Establishment of health insurance scheme

The Government's planned establishment of a health insurance scheme, in partnership with the MDG monitoring office under the auspice of the President of Nigeria, to further remove financial constraint confronting access to health care in the state seemed not to be in existence as narrated by the key informants interviewed. They claimed not to know anything about this component of the Abiye scheme. In the words of some of the respondents:

"Insurance scheme for pregnant women? I don't know……can't remember anything like that!!!! Maybe you ask nursing mothers and pregnant women……that appeared on papers……. nothing like that" (A male top management staff, KII)

"I am not sure that's functioning but we can see other strategies working well" (A male doctor, KII)

"Insurance? I am hearing it for the first time from you" (A female nurse, KII)

The comments obtained from FGD participants also corroborated that the health insurance component of the Abiye scheme did not see the light of the day. Some said they had never heard about it while few that had heard about it claimed it had no effect.

A nursing mother in her late 30s remarked:

"Kee je be"? Which literally means "What does it mean?" (A nursing mother, FGD)

Utilization of health rangers

Most key informants agreed that there were a number of health rangers (HR) operating across the state but that they were grossly inadequate and not well equipped. They opined that the planned ratio of 1 health ranger to about 25 pregnant women was not a feasible idea across the whole state considering the population of pregnant women and workforce available.

A key informant answered:

"Yes, in Igbara Oke area, some women benefited from it but how many were they compared to total number of pregnant women in Ondo state?" (A male top management staff, KII).

A nurse had pointed out that:

"Government is trying in this regard too……I know some of them….they have been going around but they are not enough"…. (A female nurse, KII).

A doctor said:

" Yes, I am aware but I don't think they are effective" ... (A male doctor, KII)

Another nurse explained that the government had been putting in considerable efforts to improve on the health rangers' initiative, but they are yet to recruit a sizeable number of health rangers that can cover the entire state due to the huge finances.

Other key informants who claimed to have heard about the health rangers wondered if the health rangers were well equipped with adequate transportation mediums such as motorbikes, speedboats, ambulances and communication materials such as mobile phones.

A doctor said:

"I don't really know, but their activities are unknown to the supposed beneficiaries …….that

signifies that they are probably not adequate, ill-equipped and unmotivated" (A male doctor, KII). The nurses among the key informants were asked if they had come across an ante-natal clinic (ANC) attendee who had been visited by a health ranger. Only one of the nurses interviewed claimed to have ever attended to a client who had received the services of a health ranger. Specifically, she said:

"*Yes, only one"……. (A female nurse, KII).* The participants of the various FGDs were asked about their awareness of the health rangers and if they had ever been visited by the health rangers and how helpful the health rangers had been to them. None of the discussants in any of the FGDs conducted across the six facilities claimed to have seen or had been visited by any health officer or any health ranger. Quotes from some of the participants are stated below:

"No, no one has visited me"………… (A nursing mother, FGD).

"I heard about it when I booked but nobody visited me" ………… (A pregnant woman, FGD)

"There is no health ranger in riverine area o, maybe they do it in the cities" ………… (A nursing mother, FGD)

Upgrading and renovation of peripheral health facilities

According to a top management staff, renovations were ongoing in many health care facilities. He stated that in order to provide firsthand services to all pregnant women and their unborn children, the State Government has engaged in extensive renovations across various facilities. In his words:

"All General and State specialist hospitals were renovated to varying degrees. Apart from the hospitals above, there are over 480 other health centres in various LGAs which have also undergone various degrees of renovations."…… (A male top management staff, KII)

He further explained that renovations and upgrading were not restricted to only physical buildings but also included staff recruitments, and provisions of amenities to equip the health facilities.

Some of the key informants however did not agree that much was done with respect to the upgrade and renovation of existing peripheral health facilities. A doctor in a comprehensive health facility lamented:

"None of the existing peripheral facilities ….you mean primary and secondary hospital….. have received any attention. They have been largely side-lined as the government only focused on the Mother and Child Hospitals" (A male doctor, KII)

A nurse in one of the selected existing peripheral health facilities prior to the commencement of the Abiye programme specifically said:

"……..The government did not include us in the programme. The situation in our hospital is still the same as it was before the Abiye started" (A female nurse, KII)

The views of the pregnant women and nursing mothers in the peripheral health facilities seemed to corroborate the assertions of the health workers in the peripheral health facilities. Most of them claimed they couldn't see any difference and that they still come to the peripheral health facilities because the mother and child health hospitals are just too far.

A pregnant woman in her early 30s said:

"No difference o, renovate as how? I still come here because Akure is far, I have used this facility for 5 years, I can't see any difference o. Government should help us and upgrade this place, our suffering is too much" (A pregnant woman, FGD)

Establishment of mother and child hospitals

Stakeholders including management, health care providers and service seekers were asked several questions on their perception and assessment of the mother and child hospitals component of the Abiye programme. All key informants and the FGD discussants at the two facilities agreed that the mother and child hospitals component is a good one that has undoubtedly met the purpose of its creation and even surpassing expectations.

A CMD of one of the mother and child hospitals remarked:

"*All evidence abound. Expectations surpassed. Delays in health seeking among pregnant women reduced and nearly eradicated" (A male CMD, KII)*

A doctor noted that:

"The creation of the mother and child hospitals has allowed the early detection of complications and prompt treatment as well as the administration of important preventive services such as tetanus toxoid immunization, prophylactic treatment of malaria, and HIV counselling and testing….(A male doctor, KII).

Most of the focus group discussants reported high satisfaction with the services received at the mother and child hospitals. All the discussants that participated in the FGDs conducted at the mother and child hospitals were excited to reel out praises and commendations on the usefulness of the mother and child hospitals. They said it has brought relief to them. The free services offered at the two facilities

was highly welcomed by the users as it has relieved them of financial burdens. They were unanimous in their remarks that the hospitals are doing tremendously well.

In particular, a pregnant woman had remarked *God bless Governor for creating this hospital. Where would I have gotten money to pay for all these services? The hospital and the workers are friendly and caring. I don't have to think of any payment. They test me every time I come without any payment." (A pregnant woman, FGD)*

The discussants were asked which factor(s) they considered in their decisions to patronize the mother and child hospitals. The discussants at the mother and child hospital, Akure pointed out different reasons for choosing mother and child hospitals. The commonest reason cited was the quality of services offered at the mother and child hospitals.

A respondent with a 6-month-old baby said:

"I chose to be coming here because they offer us quality services and because they usually attend to us very well" (A nursing mother, FGD).

Another discussant stated that the quality of caregivers at mother and child hospitals was the main reason for choosing the facility

"I chose here because there are good doctors here, it is one of the best"……………………. (A nursing mother, FGD)

Most discussants mentioned that they chose the mother and child hospitals because the services offered are free. Free medical services always attract patients especially those from low social-economic status. A pregnant woman said

"Ah, it is free o. I have not paid a kobo since I started coming here" ….. (A pregnant woman, FGD).

Others mentioned that their continued patronage of the hospital was due to the clean environment of the hospital. The attention and care received by some focus group discussants was the reason why they continued to patronise the mother and child hospitals. An FGD participant remarked specifically:

"They have been attending to us very well. Checking our children very well…there is no problem" ……….. (A nursing mother, FGD).

Despite the satisfaction and achievements about the mother and child hospitals by the respondents, the workers and patients at the mother and child hospital nonetheless have heaps of challenges. The commonest challenge reported was overcrowding. They believed that health seekers patronizing the mother and child hospitals were far higher than anticipated. These, they ascribed to two important reasons: free and high-quality medical services. These attributes had attracted more patients to the mother and child hospitals from within and outside the state. A Chief Medical Director stated that:

"Yes, despite our success, there are lots of challenges, First is inadequate staffing…although we have qualified staff, they are too few considering the number of patients we attend to….also funding is a great issue….You know this requires huge funding…….Our facilities are all overstretched….This is because our services are free and are of high quality. There are many clients from outside Ondo state and the government doesn't allow us to screen patients out…everyone arriving here must be well attended to" (A male CMD, KII).

One of the discussants in the FGD explained that a number of pregnant women and mothers often find it difficult to access the available health facilities. They claimed that the situation was further compounded with the delays patients often experience before they are attended to at those hospitals. The participants complained of the long distance of the hospitals, long waiting time, overcrowding and shortage of health workers especially the doctors.

A discussant stated that:

"There are too many patients. At times we wait so long before been attended to….I suffer before I can get here. There should be one mother and child hospital in Ore to cover the Ori-Omi sides. I arrived by 1am in the night….it would have been easy if there is one close by" (A pregnant woman, FGD)

Even though the respondents from the KIIs and FGDs commended the establishment of two mother and child hospitals as a component of the Abiye scheme, some thought that more mother and child hospitals be established across the state to serve more people.

In the words of one of the nurses:

"The establishment of the mother and child hospitals has turned around the maternal health care in the state and has further strengthened people's confidence in government as a provider of accessible infrastructures to help reduce problems faced by its citizenry but two mother and child hospitals is not enough to serve the population." (A female nurse, KII)

Another respondent also said:

"We need up to three mother and child hospital in this Akure…one in Sijuade and one in Oke Ijebu area and all over the state"….(A pregnant woman, FGD).

A second nurse reiterated:

"We need more mother and child hospital o…As I said before two in Akure and one in each senatorial district" (A female nurse, KII).

The opinion about establishing more mother and child hospitals was not a general consensus. Some respondents did not see the need for more mother and child hospitals. They rather felt the government should enable and empower peripheral hospitals to do their jobs instead of establishing more mother and child hospitals. Others also felt that the sustainability plan for the existing mother and child hospitals was even more crucial than the establishment of more hospitals. Below are quotes from two respondents.

"People have been saying so but I don't really think so. They should empower and equip what we have…..Another ten mother and child hospital will not reduce our stress. Don't forget that we are supposed to be referral centre" (A male doctor, KII)

"The hospitals are glittering today because it is new. But what happens after few years, when another government takes over? Long term sustainability should be put in place. Increase manpower. Make available other services not available in mother and child hospital setting or at least subsidize. We need off the job training" (A male doctor, KII)

Discussion

According to the key informants and the focus group discussants, it was evident that the free medical services programme for pregnant women and under-five children had led to an increased health care utilization that had impacted positively the lives of pregnant women, nursing mothers and under-five children in the state - apparent in the level of satisfaction and positive perception expressed by many of the focus group discussants. This finding mimics the positive influence of public services to the grassroots especially when they are made available at affordable costs [20].

Our findings revealed that a great deal of importance was attached to institutional antenatal care services as well as skilled birth attendance by the government of Ondo State. Antenatal care is of paramount importance in resource-limited settings that are commonly found in developing countries like Nigeria, where health-seeking behaviour is inadequate, access to health services is otherwise limited, and in which many mothers are poor, illiterate or rural dwellers [21]. Considering the strong positive association that exists between the level of antenatal care and safe delivery care, pregnant women should deliver at health facilities that are manned by qualified and skilled birth attendants[22–24].

Irrespective of the various accolades that the free medical scheme has enjoyed, some constraints were still pointed out. Although the programme was well-conceived and properly planned, a major problem identified (as is with most programs) was with its implementation.

The failure of the government to fully implement the health ranger component of the Abiye scheme was one of the drawbacks to the success of the scheme. The use of health rangers (exclusively trained Community Health Extension Workers (CHEW) that reside in communities and whose responsibilities include family planning, basic obstetric care, lifesaving skills and intensive care) is gaining more relevance in the monitoring of pregnancy-related ailments in literature [25,26].

To aid monitoring, the use of mobile technology under a closed-user group (CUG) system was adopted in the Abiye Scheme. The CUG system was made available to health workers, health rangers and pregnant women that were enrolees of the Abiye Scheme [27]. This CUG system helped in the effective management of both pre-natal and post-natal medical emergencies due to the ease and effectiveness of communication amongst all parties that have access to mobile technology.

Despite the availability of the CUG system, the available health rangers were however too few to effectively cover the whole state. They also had very little access to other supporting equipment (such as motorbikes, speedboats, ambulances on standby for 24-hour services), thus rendering the services of the health rangers non-effective in some areas within the state. Similar experience of lack of supporting equipment needed to facilitate health care delivery services to pregnant women in difficult to reach areas has been documented in other findings found in the literature[26]. As a result of the important roles the health rangers play in reducing maternal mortality and improving child health, we recommend that more health rangers be recruited and should also be well equipped with adequate means of transportation and ambulances.

The role of health insurance in enhancing maternal and child health utilization and outcomes have been documented[28–31]. As such, the establishment of health insurance is one of the cardinal

strategies of the Abiye scheme. Our study however found that the health insurance component of the Abiye scheme did not see the light of the day. Both the service providers and the service users were unanimous that the insurance component was not implemented. Whereas the health insurance scheme was designed to be implemented as a partnership with the Nigerian government MDG monitoring office to remove financial constraints confronting access to maternal health care services, it is unclear why the strategy was not implemented. It is not known if the alliance with the MDG monitoring office failed. There is need to review, strengthen, and implement the insurance component of the scheme.

A third drawback to the scheme identified from our study was the fact that the peripheral hospitals had not been adequately enabled to play their designed roles in the Abiye scheme thereby making the Mother and Child hospitals, hitherto designed to be tertiary facilities, to serve as a primary, secondary and tertiary facilities combined. The resultant effect of this is the patient overload of the Mother and Child hospitals as a result of the high demand for antenatal services (primarily influenced by the free quality services offered) on one hand, and the insufficient manpower on the other hand. The dwindling patronage of the peripheral facilities in the state can be explained by the fact that these peripheral facilities did not witness any meaningful renovations like the mother and child hospitals. The neglected and decaying structures at the peripheral facilities resulting in dwindling activities at the facilities call for concern. This was not the outcome expected of the Abiye program. The plan was to either renovate or upgrade these facilities to enable them to perform their statutory duties. The long-term health system of the state may get weaker if the government continue to focus only on mother and child hospitals at the expense of the peripheral facilities. This aligned with the assertions of Mimiko *et al* [18].

A major limitation of this study was the inability to visit more than 6 health facilities, hence the study sample might not be representative. Nevertheless, due to the qualitative nature of the study, the conclusions derived from the study are still very relevant in guiding future maternal and child health programmers in developing countries on maternal and child health policy formulation and implementation.

Conclusion

Despite the good conception and planning of the Abiye programme, the laid down plans and strategies to accomplish its goal were not fully implemented. Nonetheless, the programme has impacted positively on its targeted population to an extent. Based on the findings of this study and in order for the Abiye programme to attain its goal, the insurance component of the scheme must be reviewed, strengthened and implemented. Also, the health rangers must be enabled to perform their duties as multi-purpose grassroots health promotion and development agents, and involve them in wider health development agenda. Lastly, the peripheral health facilities should be renovated so that they may function maximally to reduce the patient burden and traffic at tertiary facilities.

Acknowledgements

The authors would like to thank all the health workers, pregnant women and mothers in the selected hospitals for granting us the audience and the permission to be interviewed and contributing meaningfully to the issues raised during the interviews and discussions.

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Received = 20/09/2019
Accepted = 02/09/2021