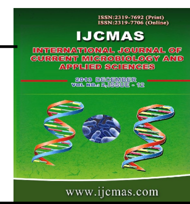

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Original Research Article

Experiences of women participating in a safe motherhood (Abiye) project in Ondo state of Nigeria

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A B S T R A C T

Abiye is a safe motherhood intervention project introduced in Ondo State of Nigeria to promote safe antenatal, delivery, and postnatal experience for women especially in rural communities. Being the first of such intervention programme in Nigeria, it was essential to learn from the experiences of women participating on the programme to draw lessons for future planning. The aim of this study was to explore experiences of women participating in Abiye project. The study employed a qualitative research design using focus group discussion with 23 service users. The discussions were tape-recorded, transcribed, translated and then analyzed using content analysis method. Five themes emerged from the analysis. (i) 'Environment and attitude of staff', points to the influence of physical environment and health worker's attitude on utilization of Abiye project. (ii) 'Awareness and cost of services', is an illustration of how awareness and cost determines utilization of Abiye. (iii) 'Health worker – patient communication' describes the impact of home care on Abiye participants. (iv) 'Unmet expectations' refers to the frustration of not being able to access all the services Abiye provides. (v) 'Cultural beliefs and gender inequality', describes the circumstances and actions preventing participants from delivering in Hospital settings. The themes were discoursed and implication for health care programming highlighted.

Keywords

Abiye project; Safe motherhood; Ondo State; Mother and Child; Maternal and Child's health; Qualitative Research.

Introduction

Maternal and child health is a complex public health problem, over 536 000 women dies worldwide from pregnancy related complications and childbirth every year (WHO, 2007 in Kongnyuy, Mlava and Broek, 2009). Though Maternal mortality ratio in Nigeria has shown some degree of decline in recent years from reported 1100 per 100, 000 in 2005 (Hill *et al*, 2007) to an estimated 840 per 100, 000 in 2008 (Nigeria demographics profile, 2011). This figure, according to Okonofua *et al* (2011) still remain one of the highest ratio in the African continent and one of

the fifteen countries worldwide with the highest under five mortality rate. Nigeria has a high concentration of people living in extreme poverty, World Bank report (2008) reveals that about 71% of Nigeria population lives below the poverty line, that is about 110 million 203 thousand and 56 people using the latest population estimate of 155, 215, 573 from the Nigeria demographics profile (2011).

With such huge poverty level, the outcome was as described by the Nigeria Population Commission in its Nigeria demographic and health survey (DHS) report (2008) which shows that only 64% of pregnant women in Nigeria access antenatal services, and just 35% give birth in a health facility while only 39% of birth are delivered by skilled birth attendant. Most women in Nigeria live below the poverty level and lack access to comprehensive antenatal and delivery services (Onah, Ikeako, and Iloabachi, 2006). Infant mortality figure is also staggering; Child mortality rate under age 5years was 143 per 1,000 births in 2010 compared with 5 per 1,000 for United Kingdom (World Bank, 2011).

Most women of reproductive age in Nigeria lives in village settings where it is difficult for pregnant women to access ante/post natal programmes and deliver in hospital settings despite research figures attributing 76% of infant mortality to home delivery without the presence of skilled birth attendant (Walraven *et al.*, 1995).

It was to meet the challenges faced by these women and reduce the high maternal and child mortality rate that a safe motherhood project tagged ‘ABIYE’ was introduced by Ondo State Government of Nigeria. Being the first of such intervention programme in Nigeria, it was essential to learn from the experiences of women participating in the programme to draw lessons for future planning.

Materials and Methods

Study Design

The aim of this study was to explore experiences of women participating in Abiye project. The study employed a qualitative research design using focus group discussion with 23 service users. The discussions were tape-recorded, transcribed, translated and then analyzed using content analysis method.

Study area

Ondo State, one of the 36 states in Nigeria is located along the south-west region of the country with a population of 3.5 million (National Population Commission, 2010). The World Bank in 2009 declared Ondo state has having the worst health indices in the Southwest Nigeria (Punch News Paper, 2010). This declaration necessitated a total reformation of the health system in the state. On assumption of office in 2009, the state governor Dr Olusegun Mimiko outlined a 12 points agenda tagged ‘A CARING HEART’ with a comprehensive health sector reform and initiation of a safe motherhood programme in collaboration with the World Bank called ‘Abiye Project’.

The project was piloted in Ifedore Local Government Area located in the central senatorial district of Ondo State with igbaraoke community as the headquarters. Nigeria operates three levels of government; The National, State and Local governments. The country is divided into 36 States, and the States sub-divided into Local Government Areas, the number

of local governments in each state varies and depends on the size and population of the state. Comprehensive Reports and data from Nigeria are insufficient; where available they remain unpublished (Ansa *et al*., 2006). Therefore, researches are based on the limited available data, which are mostly from newspaper articles and donor agency reports like WHO and UNICEF.

The Abiye Project

By virtue of the Abiye project, pregnant women and children under the age of five are entitled to free healthcare. The goal of the project is to reduce maternal and infant mortality, and safeguard maternal health through the early detection and treatment of four major causes of maternal mortality: severe bleeding, infections, hypertensive disorders and obstructed labour. Part of the Abiye initiative is the establishment of Health Rangers Scheme made up of trained officers equipped with communication gadget and mobility machines that is useful in rough roads that commonly link the rural communities. The mandate of the Health Rangers is to maintain constant contacts with pregnant women assigned to them individually to monitor their health and offer immediate assistance when needed. Each registered pregnant woman is issued a toll – free mobile phone for easy communication with health rangers in case of emergency. A reference hospital called 'Mother and Child Hospital' was also built in Akure, the state capital to attend to mother and child complications that could not be handled at the basic or primary health centres.

The programme has witness 1,031 deliveries out of about 3,000 registered women as at 2010 (Coaster News, 2011). The Abiye project is to be replicated in all the 18 Local Government Areas of the state hence the need to explore the experiences of women participating in the programme as this could suggest areas of improvement in subsequent programmes under similar settings.

Sampling

A purposive selection based on registration on the 'Abiye' register between 1st June 2010 and 31st June 2011 (covering a period of one year) was used to select participants. The Ondo State Ministry of Health granted access to the state Abiye register.

Fifty (50) participants living within 15km radius of the Abiye clinic in Molete, Igbaraoke (for logistic reasons) Ifedore local government, currently pregnant or already given birth were randomly selected from the Abiye register, no matter whether the women finally gave birth on the programme or not. (Table 1)

Data Collection

Tape - recorded FGDs were used to collect data following the pattern of Kasenga, Hurtig and Emmelin (2010). Two different group discussions were held with two separate groups to bring out different perspectives based on level of participation. Twenty Three women participated in the group discursions, 10 women on postnatal and 13 women on antenatal. The discussions were conducted in local (Yoruba) language. Data collection was deemed complete as no new information seemed to be emerging after the second group. Each FGDs lasted btw 60 to 90 minutes.

The participants were asked to share their experiences, feelings and reactions on the following questions;

- Why did you decide to register on the Abiye programme?
- What is your opinion of the different programme staff (Health Workers) you have had contact?
- What led to the final decision of whether or not to make use of the programme in giving birth? (for those who have given birth already)
- Do you think you will give birth on this programme (for those on antenatal)

  Further probing question include;
- What do you think about the care you have received?
- Would you recommend the service to a friend?
- What did you like most and least about the service?
- Where will you deliver in the future if pregnant?

Data Analysis

Each tape – recorded discussion was transcribed word – for – word, translated to English language and analysed using 'Content Analysis' method following guideline set out by Graneheim and Lundman (2004). The data was transcribed and translated cautiously, precisely and plainly in its entirety to capture the exact words used by the participants and maintain integrity of data (Polit and Hungler, 1999; Polit and Beck, 2009). The identified issues were assigned codes by reviewing transcripts and discussions, the codes were then merged into themes for discussion. (Table 2)

Ethical consideration

Consent was obtained from Ondo State Ministry of Health, Nigeria. Further approval was obtained from University of Wolverhampton School of Health ethic committee. All participants signed a consent form with an assurance that information given would be treated with strict confidentiality.

Results

Twenty-three (23) women participated in the study, thirteen (13) on postnatal and ten (10) on antenatal with age ranging between twenty (20) and forty (40) years. Six (6) of the women on postnatal had first babies while three (3) women on antenatal are carrying their first pregnancy. Only three (3) of women in the study gave birth in an Abiye clinic while another three (3) gave birth in hospital setting, all other women gave birth at home, with traditional birth attendant, or in a religious building.

Eight themes emerged from the analysis; these are Physical Environment, Attitude of Staff, Level of Awareness, Cost of services, Communication and home visit, unmet expectations, cultural beliefs, and gender inequality. However, a thorough examination of the transcript reveals that some of the themes are linked together under the same context. For instance each time a participant talk about level of awareness, it is in relation to the cost of services. Moreover, the environment is strongly linked to the kind of reception the participants received from the workers each time they visit the hospital. Therefore, some of the themes were merged based on the context of where the theme emerged.

Merging reduced the themes from eight to five key themes, which described the perceptions of women registered on the

Table.1 Selection of participants

Particulars	Postnatal	Antenatal	Total
Number selected	31	19	50
Number removed because of dead babies	3	0	3
Number contacted	28	19	47
Number of consent returned	18	15	33

Table.2 Sample of data analysis process

Meaning units	Codes	Condensed codes	Themes	Merged themes
The first time I got here I have a good impression of the staff	Good impression of staff	Attitude to patients	Workers' attitude to work and patients	
The staff here are accommodating	Accommodating staff			
The nurses are not harsh	Friendly nurses			
I was surprised at the nurses' hospitality	Hospitable nurses			
The nurses are trying and working hard	Hardworking nurses	Attitude to work		
The nurse do attend to us on time	Responsive nurses			
The nurses do visit me very well	Nurses' regularity			
The cost of having a baby ... here is better	Cost	Cost of services	Cost of services	Awareness and cost of services
The nurses do not money	Cost			
I can't dream of a nurse coming to check on me personally, but here is it without additional cost	Cost			
We experience free health and other free things	Cost			
We travel to ... for scanning	Cost	Cost of transportati on		
To do scanning you paid 1500 to 2000 naira and transport yourself	Cost			
Will don't have to travel at all	Cost			
I do see how they visit my neighbour	observation	Available information	Awareness	
I know all the nurses, they are my friends	Personal contacts			
They say it on radio and television every day	Media publicity			

Abiye project.

(i) 'Environment and attitude of staff', points to the influence of physical environment and health worker's attitude on utilization of Abiye project.
(ii) 'Awareness and cost of services', is an illustration of how awareness and cost determines utilization of Abiye.
(iii) 'Health worker – patient communication', this describes the impact of home care and visit on Abiye participants.
(iv) 'Unmet expectations', refers to the frustration of not being able to access all the services Abiye provides.
(v) 'Cultural beliefs and gender inequality', describes the circumstances and actions preventing participants from delivering in Hospital settings.

A number of studies all over the world have focused on service users' experiences with very few in Nigeria (The Prevention of Maternal Mortality Network, 1995 In Luck, 2009). The Abiye project is designed to encouraging maximum utilisation and overcome the general socioeconomic barrier.

This study aimed at presenting clearly the findings from the Abiye project compared with previous studies. Content analysis method used in this study produced five themes, which include Environment and attitude of staff, Awareness, and cost of services, Health worker – patient communication, Unmet expectation, Cultural beliefs and gender inequality. Both the theoretical implication and practical applications of the emerged themes discussed.

Environment and attitude of staff

A significant factor encouraging utilization of the Abiye project is the physical environment and the attitude of staff towards service users. This is an important finding as only limited studies have examined the relationship between the attitude of service providers and utilization of services by the end users in the past (Ehiemere *et al.,* 2011; Glei and Goldman, 2000; Fatusi and Abioye-Kuteyi, 1998). Glei and Goldman (2000), Fatusi and Abioye-Kuteyi (1998) reported preference for traditional birth attendants (TBAs) by many Nigerian women because such TBAs are rated to be of higher quality in interpersonal communications and relationship than health workers. TBAs have been reported to be more considerate and provide care that is more compassionate. On the other hand, health workers have been criticized for lack of social support (Glei and Goldman, 2000).

Results of this study show that the disposition and attitude of health workers is an important factor in determining whether an intervention will be acceptable. The participants were animated mostly with broad smiles when describing the attitudes of the health workers. A deep sense of satisfaction was felt in the participants' voices. The choice of words used by many of the participants highlight the importance attached to health workers' attitude by the participants. Such words include:

"The staffs here are accommodating"
"They (health workers) are not harsh like staffs in the other hospitals"
"They (health workers) are friendly"

This finding is however contrary to the findings of Ehiemere *et al* (2011) in a study of patients' satisfaction in a tertiary hospital in Nigeria. In the study, 37.5% of patients concluded that the nurses are harsh, an additional 37.5% reported that they not satisfied with the way the nurses address them while 12.5% of respondent complained that the nurses are not responsive to calls. The words of the participants in this study suggest that unfriendly health workers is a common phenomenon, therefore there must be a factor responsible for the friendliness of health workers on Abiye project setting them apart from their counterpart in other hospitals.

In a study to examine the effect of physical working environment on job satisfaction, Applebaum *et al* (2010) concludes that common environmental stressors in the work place can influence job satisfaction. Many of the participants reported being influenced by the physical hospital environment that are neat and more equipped than other conventional government run facilities. The environment probably may have affected the health workers as well. This is consistent with Nolan, Nolan, and Grant (1995) study that linked working condition and nurses' job satisfaction.

If health workers' attitudes towards service users continue to improve, it could have a positive effect on service utilisation toward reducing maternal and child morbidity and mortality since research figures attribute 76% of infant mortality to home delivery without qualified attendant (Walraven, 1995). The implication of this for health care delivery in Nigeria is that if more investment in health workers' job satisfaction is made a priority, it could create good patient – nurse relationship that will improve hospital attendance and utilization of intervention services. Therefore, factors influencing job satisfaction of health workers on the Abiye project compared with workers in other settings should be subject of further research. Findings from such research could help create a responsive health workforce that is user friendly and patient centred.

Awareness and cost of services

Cost of available services including the cost associated with transportation have been identified in numerous studies to affect utilization of health care services (Kasenga, Hurtig and Emmelin, 2010; Pell *et al.,* 2011; Luck, 2009; and Prata *et al.,* 2010). Whereas a high level of awareness of healthcare interventions, have been reported to increase utilization in certain settings (Luck, 2009). The Abiye project was designed to be free at the point of delivery, which is an encouragement to the economically challenged families in rural Ondo State. Many participants reported utilizing the Abiye project because of the level of awareness and the word 'free' attached to it. Some of the expressions that illustrate the perception of the participants on the cost associated with the Abiye project include;

"The cost of having a baby in hospital is usually too much to bear, but this is better"

"I like this Abiye program because they don't collect money for their service, they do it free of charge"

In a systemic review highlighting factors affecting utilization of antenatal care in developing countries, Simkhada *et al* (2008) identified cost, household income,

and media exposure (awareness) as contributing factors to service utilization. Okonofua *et.al* (2011) and Antai (2009) also included elimination of user fees in public hospitals for pregnant women and children less than five years of age, as well as advocacy and public enlightenment in their list of strategies to reduce maternal and child mortality in rural Africa. Lagarde and Palmer (2008) however noted that while reduction or elimination of user fees was found to increase utilization of services in certain settings, such approach could have a negative impact on service quality.

Removal of user fees hard tremendous impact on hospital delivery in the Abiye project. Emeh (2009) in his final report of the health baseline survey in Ifedore Local Government reported 472 registered delivery within a 12 months period prior to the kickoff of Abiye project. These when compared with 1, 031 deliveries (Coaster News, 2011) in 12 months after the kickoff of the project, represents 118% increase in hospital based delivery since the inception of Abiye.

While removal of user fees seems to have encouraged utilization of Abiye project, it appears to have affected quality of service delivery. Respondents noted the negative effect of lack of scanning machine in the local government of implementation, forcing users to travel a long distance to get scanning pictures at a high cost. The participants feel they cannot complain about such equipment that is not readily available since the services are 'free' thereby creating a quality and satisfaction gap. However, government have the responsibility of providing health care for citizens, Elwood and Longley (2010) encourage that the public should be involved closely and openly in decision making in all matters relevant to health. Such dialogue could have afforded the end users of the Abiye project the opportunity to decide on available services either totally free or at minimal cost where government cannot afford a free service. In England, though scanning is offered free for pregnant women, getting a copy of the picture, which is optional, costs £5 (about 1, 250 naira) at an NHS hospital according to recent service users.

Though Okonofua *et.al* (2011) and Antai (2009) encourage elimination of user fees in public hospitals for pregnant women and children less than five years of age to reduce maternal and child mortality, there is a need for studies to investigate the sustainability of such approach especially in resource poor settings.

Health worker – patient communication

The comprehensive organizational structure that is patient centred is a significant attraction for some of the women participating on the Abiye Project. Following the recommendations of Prata *et al* (2010), the implementation strategy of the Abiye merged different evidence based strategy at improving maternal and child health. The project provides opportunity for women to access services without leaving the comfort of their home. The comprehensive structure, especially the homecare innovation at no additional cost to the expectant mother and her family encouraged high turn up and wide spread acceptability. Such home care is very important in Sub – Sahara Africa where pregnant women don't usually understand the importance of accessing antenatal care early unless they felt ill (Waiswa *et al.,* 2008). In their 1986 study of low-income mothers, Olds *et al* discovered that women who were visited

by nurses were more aware of community services and attended antenatal classes more often than those that were not visited. The study also reports an increase in family support and a reduction in preterm delivery among visited mothers (Olds *et al.,* 1986).

A recent BBC report (BBC News, 2011) showed no significant relative risk associated with home birth after the first pregnancy compared with hospital birth when birth is attended by a skilled midwife. If sustained, the strategy of home visit is capable of improving maternal health care in rural Africa by shifting attention from much emphasized hospital facility based care to a more acceptable community care, since studies have shown that most rural and peri-urban Nigerians culturally use community and family support system that encourage home birth (Okonofua *et al.,* 2011). Though findings in this study shows that the strategy of home visit and community care encourages utilization of services by pregnant women, whether the strategy was actually successful in reducing maternal and child mortality should be examined in future studies.

Unmet expectation

Effectiveness of public spending on health care has been an issue with African countries, Castro – Leal *et al* (1999) for instance submitted that such spending though directed at the poor ends up favouring the affluent more than it favours the poor. Hargreaves (2002) in her paper on improving basic health care in Nigeria quoted Chinua Achebe – a famous Nigerian novelist as saying *"... the Nigeria problem is the unwillingness or inability of its leaders to rise to the responsibility, to the challenge of personal example which is hallmark of true leadership..."* Hargreaves concluded, *"Political priorities are being put ahead of population's basic needs"* by the leaders.

Putting political image and acceptability of political ideas ahead of primary responsibility of caring for its population continue to be a setback in major health intervention programmes like the Abiye project. The government is always quick to mention the words 'totally free' when referring to the project, the introductory words on the official webpage of Mother and Child hospital Akure reads in part "... facility dedicated to the care of pregnant women and children less than 5 years of age, offering tertiary level health services free of charge" (http://www.ondostate.gov.ng/mch2). The government also claim to have provided tricycle ambulances to convey both health rangers and pregnant women to and from their homes and the hospital in cases of emergency.

The participants however insist such stories are a complete distortion of the truth and misleading aimed at gaining popularity and attract external donors. So far, only bikes were provided for the health rangers. Most of the health rangers are women and cannot ride the bikes provided by the government. Words and facial expression of the participants at this stage is in complete contrast to what was observed when reacting to questions on the attitude of the health worker. Some of the expressions used include:

"This issue of free, the government should stop lying to people"

*"Our government can never stop using us to get money from the Whites (*external donors*)"*

"The government should do the right thing and stop lying to people on television"

"Let them put it free or say it out that we will pay little so people will stop saying it is free"

The effect of such unfulfilled promises is evident from the number of women utilizing the programme in giving birth. Though many registered on the programme and attended antenatal or receives regular home visits, a large number of participants did not give birth on the programme. Some participants claimed that inconvenient mode of transportation is partly responsible for the decision not to give birth on the programme;

"*...my in-law when she wanted to give birth, its 5days earlier than the date they gave her. She started labour, we call the nurse, but she said nobody to bring her to our side that we should come to the hospital. I don't think it is good to put someone in labour on okada, so she ended up giving birth at home..."*

"...Even in my area if the nurse want to transport someone in labour they will tell her to wait, the okada will first go and drop the nurse before coming back to carry the pregnant person. You know anything can happen on the way when the nurse is not there..."

This is consistent with findings of Gage (2007) in a study of maternal health service utilization in rural Malawi. The study reveals that transportation and distance barriers affect the rate of institutional deliveries.

Though the government have a good programme with well-planned strategies for implementation, the smooth implementation of Abiye project has been hindered by breaching the public trust. Such unfulfilled promises if not addressed could adversely affect public acceptability of future government run interventions.

Cultural beliefs and gender inequality

Community and cultural preferences, attitudes and norms plays an important role in the health seeking behaviour of people in general, this is evident in reluctance to seek health care for women outside home and community resistance to the use of modern medical care to assist with pregnancy in some parts of the world (Ensor and Cooper, 2004). Though the response to Abiye project is high, the number of women utilizing the service for delivery is very low compared with the number of registered pregnant women. Out of the 13 postnatal participants, only 3 (23%) utilized the project for delivery while 7 (54%) delivered in either a religious building or with a traditional birth attendant. A recent published figure on the webpage of Mother and Child Hospital Akure (reference hospital for Abiye project and coordinates data from all Abiye clinics) indicate a total antenatal registration of 15, 748 as at 31st December 2011 but only 8, 770 deliveries recorded from both normal and caesarean deliveries. That represents about 55.7% utilization level (http://www.ondostate.gov.ng/mch2/?page_id=426). The low level of utilization and preference for non hospital based delivery is however consistent with findings from other studies both in Nigeria (Olaogun *et al*., 2006 In Okonofua *et al.,* 2011; Osubor *et al*., 2006) and other parts of the world (Gage, 2007; Magadi, Madise and Rodrigues, 2000; Ochako *et al*., 2011; Mrisho *et al*., 2009)

Gender inequality is a cultural factor in Africa with the male gender having an overwhelming authority and decision-making power (Boer and Mashamba, 2007). Gender inequality in Africa has been implicated in the rising level of domestic violence and other health complications across the continent (Jewkes and Morrell, 2010; Jewkes *et al*., 2010). Many participants in this study believe that taking decision on where to give birth is a responsibility exclusively reserved for the husband and in – laws, especially the mother in-law. Most of the time, the husband, or his family dictates where a woman delivers and what level of care she receives. Some participants described it this way

"...Once something is family tradition, you just have to follow it as well. In my husband's house the custom is to give birth where the mother in-law is, it's like that with most people and you can't change it. That is the tradition here and most people like me have no option than to obey..."

"...It is not the responsibility of a woman to decide where she will give birth. I really want to give birth at the other Abiye centre close to my house but I stay with my husband's family and they said they have their own place of delivery. The nurse really tried talking to them about it but they refused, I had no choice..."

"...My husband insisted I should go to his grandmother to give birth..."

"...I deliver in my mother in-law's place. That is how they do it in my husband's family..."

This is consistent with Peek *et al* (2010) conclusion that men, whether in their family roles as husbands, partners, fathers, brothers or in their social roles as leaders and elders are often the key decision makers within the family and community. Changing culture and tradition is difficult to achieve, but orientation of the male gender and their involvement in maternal and child health issues have been advocated for at all levels (Prata *et al*., 2010; Roth and Mbizvo, 2009; Luck, 2009). Despite lack of decision-making power by women, most health education programmes aimed at encouraging modern maternity care in Africa focused primarily on women (Roth and Mbizvo, 2009). The implication is that though the women are aware of available services and dangers associated with home birth without medically qualified attendant, the awareness is buried inside women since they are not in position to dictate or make decision. The male gender responsible for making decision is thus left without adequate information to make informed decision.

For the Abiye project to be successful in improving hospital-based delivery or delivery by a medically trained attendant, male involvement is essential. One participant gives this open admonition;

"*...It is a big issue and I think you people can help by talking to husbands as well..."*

Therefore, interventions aimed at improving maternal health must also target those that are either responsible for, or influences a woman's decision. This is a classic illustration of the conclusion of Dahlgren and White (1991) where they indicate that effort aimed at improving health should target the outermost layer of their rainbow for social model of health (the general socioeconomic, cultural and

environmental conditions) to guarantee the highest impact.

The findings from the study reveal there is no universal set of factors that could be applicable to all forms of health services or intervention programmes. Each service is being influenced by different factors depending on region, culture, and implementation strategies of such programmes. Though factors like cost, distance and awareness seems to be cross cutting factors, the particular way it influences utilization and service uptake differs from one intervention to the other and from region to region. The particular importance of physical environment and health worker's job satisfaction in improving health workers' attitude to work and patients have been identified as a boost to patient – health worker relationship. Any gain achieved through motivated and dedicated staff will continue to be loss unless more attention is giving to the role of male gender in reducing maternal and child mortality.

This study raises a number of issues for future studies. These include studies to measure the effect of Abiye project in reducing maternal and child morbidity and mortality. Research to examine the effect of home visitation on maternal and child mortality; study establish factors responsible for the friendly attitude of health workers on Abiye project; and a study to determine the sustainability of user fee elimination in public hospitals in resource poor settings like Ondo State of Nigeria.

Limitations

A notable limitation of this study is that the participants were all participating on the programme, and utilized the programme to certain level. This has limited the findings to factors encouraging utilization. Factors discouraging women from utilizing the programme will have been established by interviewing women who fail to utilize the programme. This however has no effect on the findings as the study was aimed at exploring experiences of women 'participating' in the Abiye project.

There is no conflict of interest in this study as it is an independent study, the state government or its affiliates did not sponsor this the study, nor was it intended for political or economic gain.

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