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Intervention Programmes and Policies for Maternal Mortality Reduction in Zamfara State, Northwest, Nigeria: A Review 2005-2015

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Abstract
Estimates indicate that Nigeria has more than 50,000 maternal deaths annually, while many key maternal health indicators have remained stagnant or have worsened over the last decade, and coverage and utilization of key interventions are correspondingly low. The maternal mortality in Nigeria is 576 per 100,000 live births according to Nigeria demographic health survey 2013.This study used both quantitative and qualitative methods as well as secondary data to review the interventions program and policies for the reduction of maternal mortality in Zamfara state. The results indicated that socio-cultural issues, non-utilization of health facilities and preference for home deliveries by mothers remain some of the major reasons for the high maternal deaths. Other institutional factors include insufficient manpower and frontline health care workers. There are obvious gaps in policies, funding and political commitment, poverty, weakened capacity of public institutions, low literacy levels and other entrenched negative health seeking behaviours.

Keywords: *maternal mortality, maternal health, policy, interventions, Zamfara State*

Background to the Study

Nigeria has the highest number of maternal and child deaths in sub-Saharan Africa and is second to India globally. Every year 33,000 Nigerian women die during child birth. The maternal mortality rate in Nigeria is 576 per 100,000 live births according to Nigeria demographic health survey 2013 (1). This rate is higher than the sub-Saharan average and the 19th highest global rate. Nigeria's under-5 mortality rate is 170 per 1,000 live births (2). The Northwest region of Nigeria, where Zamfara is located has some of the worst maternal and reproductive health statistics, generally much poorer than the national average within the last decade. The 2008 Nigeria Demographic and Health Survey (NDHS) estimated a nationwide maternal mortality rate (MMR) in Nigeria at 545 (3). While the United Nations Children's Fund (UNICEF) has estimated MMR in the Northwest to be 1025 which is almost doubled the national average (2). While use of all methods of contraception is low nationwide (15.4%), it is still lower in the Northwest (2.8%). Similarly the percent of women who had a live birth in the five years preceding the survey who received ANC from a skilled provider was 57% for Nigeria; only 31.1% for the Northwest. Comparing additional key indicators for maternal and newborn health between the Northwest and the National average for Nigeria indicates fertility rate of 7.3 compared to 5.7 national average and contraceptives prevalence rate of 2.8% compared to 15.4%. The high levels of MMR and total fertility rate (TFR) and the low contraceptive prevalence rate (CPR) reflect the low utilization rates of maternal and new born care services including FP, as well as inadequate availability and accessibility of services and skilled service providers (4,3).

The 2013 National Demographic and Health Survey still showed that the Northwest is still having the lowest antenatal care and delivery by skilled provider at 41% and 12.3% respectively (1), while the figures for Zamfara State also still remain static and bleak despite corresponding interventions by both government and development partners. Home delivery account for over 90% with Non skilled birth attendants (NSBA) or Traditional birth attendants (TBAs) playing more role than skilled birth attendants in the zone and in Zamfara State (5).

Similarly, maternal mortality and neonatal mortality remain unacceptably high within the zone. Consequently, the state government and a number of international donor organizations are currently intervening to improve maternal and child health in the state but with limited reach. In addition, the state government for almost a decade since 2001 has introduced the Free- Maternal and Child Health Care policy but is hampered with challenges such as changes in the political leadership in the state, insufficient funding to the health sector, inadequate health personnel, drugs and hospital equipments. The Zamfara State government has introduced several policies aimed at mitigating the maternal and child deaths with support from several funding agencies but yet there is but little improvement in the maternal health situation of the state. Though, in collaboration with some donor partners the state government has piloted new approaches that has significantly improved antenatal clinic attendance (ANC) but with no observed impact on hospital delivery (5,6,7). The aim of this study is to review and identify the past and present interventions and policies for improving maternal health

and consequently reducing maternal mortality in Zamfara State from 2005 to 2015.

Methodology

Study Location: Zamfara state is located in the North western part of Nigeria. The state is bordered by Sokoto and Niger Republic to the North, Kaduna State to the South, Katsina state to the East and Kebbi and Niger states to the West. It occupies a land mass of 38,418SqKm with a population of 3,259,846 people based on 2006 National population census. The inhabitants are mainly Hausa/Fulani Muslims who are majorly peasant farmers.

Study Design: This study uses mixed methods, a quantitative survey of health workers in some government health clinics and ministry officials, pregnant women attending antenatal care clinics. Also a qualitative method involving key informant and in-depth interviews with heads of health facilities, officials of the state ministries of health and budget and economic planning as well community members and religious leaders in Gusau, the state capital of Zamfara State was conducted. Staff of non-governmental organizations (NGOs) and international donor partners were also interviewed. This study was conducted between December 2013 and November 2014.

Ethical permission: the study was received as part of the approval for the health promotion and prevention of maternal mortality (IIUM project) by the Zamfara State Health Research ethics Committee on 6th November 2013.

Results

Maternal health situation in Zamfara State

In survey by PRRINN / MNCH in 2012 it indicated that the MMR for Zamfara State was 1049 (8, 13), while a recent study in the state shows a maternal mortality rate of 994 per 100,000 life birth. This is more than twice the national average. Though he estimated maternal mortality ratio in 2013 (576) is almost the same as in the 2008 NDHS (545) yet the MMR in Zamfara still almost double the national average. Yet there is no improvement in some of the maternal health indicators also in the 2013 NDHS as antenatal care and delivery by skilled provider is 22.4% and 5% respectively in Zamfara state (1).

Current, Previous and Past Intervention Approaches in Zamfara State

Zamfara State Government is implementing some state supported interventions such as the Integrated Maternal Child Health (IMCH) Weeks. The UK Department for International Development (UKaid) and Norwegian Government is funding the new Maternal Newborn and Child Health (MNCH2) Project a five years follow on to the Partnership for the Revival of Routine Immunization in Northern Nigeria and Maternal Child Health (PRRINN-MCH) project Programme which was implemented in five Northern States from 2009 to 2014. Other past interventions by other international donor agencies such as United States Agency for International Development (USAID) funded projects including the Access to Clinical and Community Maternal and neonatal and Women's Health Services (ACCESS)/ Maternal Child Health Improvement Project (MCHIP) intervention which was implemented in three states JHPIEGO from 2007 to

2012 to mention a few. However, most of these approaches did not cover the entire state with their intervention but was conducted in some selected communities and Local Government Areas in the State.

Table 1: List of programmes and interventions on maternal and child health in Zamfara State by International Development Partners from 2005-2015

Table 1 in the supplementary indicates the lists of all the programmes and interventions by international development partners in Zamfara State which were aimed at complimenting the effort of the state government or buying-in into the states interventions or existing programmes if any from 2005 to 2015. It is clear that in the last ten years the state has enjoyed and support from the international development partners programs and interventions however, in most situation most of the projects are either piloted in some selected clusters, communities or LGAs and some cases the projects are vertical projects though some were integrated maternal child health project- the maternal and child mortality still remain high as corroborated in the study (5, 6, 1).

Table 2-Other Programmes and with direct implication to maternal health interventions in Zamfara State

Table 2 in the supplementary appendix: Also indicate other recent interventions and programs that were implemented in Zamfara State by the both the federal government support and other collaborative efforts with other bilateral and multilateral agencies with aim of contributing to the reduction of maternal mortality and achieving the MDGs goal 4 and 5 in the State. For example the MDGs project through its various programs conducted renovations, repairs and training of health workers in the states since 2007 to date. These projects were jointly sponsored with counterpart funding from the state government and the proceeds of the debt relief gains.

The SURE-P MCH Project aimed at improving children and mothers' health through improvement of skilled birth attendants, renovation, repairs and construction of health facilities and supply of drugs and equipment, is a federal government of Nigeria initiative to apply subsidy savings to reduction of maternal deaths and improvement in maternal and child health in Nigeria. The program did not cover the whole state but worked in some selected communities or LGAs in the state. Under this programme Midwives were recruited through the National Primary health Care development Agency (NPHCDA) and were posted to some selected primary health centers across the country in which also Zamfara state benefited (9). Also the program trained and retrained health care workers on live saving skills curriculum which also does not cover the whole state. The Sure-P programme in an attempt to improve and increase the delivery at the health facility by women and with a skilled attendant provided conditional cash transfer to women for completing three ANC visits and delivering at the hospital. The traditional birth attendants and village health workers and committees were also part of this program for referring the pregnant women or escorting them to deliver at the health facility.

Table 3: Other Programmes with indirect implications for maternal health interventions

Table 3 in the supplementary shows other program and interventions that are not directly health or maternal health programs but which may have indirect implications to the improvement of maternal and child health in the state within the last decade. These programs are a combination of federal government intervention and with the support of international development partners or bilateral in other development sectors. Most of these programs in this category are those that may require the state government's counterpart funding which appears not forthcoming in recent years as indicated in the table for some of the projects.

Table 4: Responses from Health Care Workers in some Health facilities in Zamfara State

Do you think or know that there are State/Federal policies in place to reduce maternal mortality	(N=60)
Yes	53.4%
No	43.1%
Dont know	3.4%

Do you think the policies are being implemented	(N=60)
Yes	46.6%
No	51.7%
Dont know	1.7%
Are there specific laws or edicts in respect of reduction of maternal mortality in the State	
Yes	43.1%
No	53.4%
Dont know	3.4%
Do you think Health Promotion is one of the Strategies	
Yes	70.7%
No	29.3%
Do you think the Health Sector is adequately funded	
Yes	23.3%
No	76.7%
Dont know	.0%

Table 4 above shows the responses of some health personnel who were asked various questions regarding the state policies for maternal health and their implementation in Zamfara State. Only about 53.4% of the state health workers think they know or are aware of any state policy to reduce maternal health and 51.7% said they think the policies are not being implemented. When further asked on their knowledge of specific edicts or laws for prevention of maternal death more than half of them are not aware of any while 76% of the respondents felt that the health sector is not adequately funded. On the strategies for reduction of maternal mortality 70% of the respondents think health promotion strategy as a key strategy for reduction of maternal deaths in the state and in the country at large.

Free Maternal Child Health Programs

Policy pronouncement was made in September of 2001 with the establishment of a Free of charge services and drugs distribution for women and children under five at the King Fahd Women and Children Hospital which is been in existence since then. However this scheme which was supposed to be state-wide was only operational at the said hospital but was overwhelmed with clients and patients turn over coupled with low and poor manpower at the hospital. This program was later proclaimed to be expanded to other parts of the state but was constrained by lack of manpower and budgetary release of funds to make it fully operational. Thus "*it is just a mere window-dressing*" and "*it is not free*" to "*there are no essential or required drugs*" are some of the words of some respondents during an in-depth interviews and FGDs in this study.

Drug supplies and Equipment for health facilities

The state government has a drug supply programme called" Sustainable Drug Supply Scheme (SDSS) - which is aimed at ensuring availability, affordability and accessibility of essentials drugs to mothers and children under-five years. The programme which was adopted from the Bamako-initiative kind of drug supply started in 2008-date, where community members are supposed to be members of the drugs committee and income generated is re-used to refill and purchase the drugs. The programme started well and has a component of sustainability but is also hampered by lack of enough skilled manpower to monitor and support the programme thus leading to some failures witnessed in some part of the state.

Human resource for health in Zamfara State

Zamfara has a total of 715 health facilities including private hospital out of which 22 are General Hospitals and the rest Primary Health Centres (PHCs). The large numbers of the dispensaries are located mostly in the hard to reach rural areas. There are two tertiary health facilities in the State- the Federal Medical Center (FMC) and Yariman Bakura Specialist Hospital all based in Gusau- the State Capital, and three pre-service health training institutions. Over 80% of the total Health Work force in the state are the Community Health Extension Workers out of which over 75% of them are males and 25% females who are mostly posted in the urban areas as compared to their male counterparts who accept postings to the rural areas. Zamfara State is one of the states in northern Nigeria with low numbers or few Nurse-Midwives, Doctors and Specialists such as Obstetric and Gynaecologists who are the Skilled Birth Attendants by definition.

According to the Zamfara State Health sector Mid Term Sector Strategy 2014 and available records from the State Ministry of Health indicates that there are only 8 female medical doctors out of the total 209, of whom only 8 are Consultant or specialist in Obstetrics and Gynaecology and of the total 1,035 Nurses and Midwives there are only 424 female which is 40.96% of the clinical workforce of which 290 are midwives which is only about 28.01%. There are only eight pharmacist in the services of the state government out of the total 36 pharmacists in the hole state all males which is 12% of the total 281 pharmacy staff, while the rest are pharmacy technician of which only 44 of them or 15.65% are females and the rest all males (10,11,13).

Table 5: Summary of Available Human Resources for Health in Zamfara State

Staff/Cadre	Female	Male	Total
Doctors	8	201	209
Pharmacists	0	36	36
Pharmacy Technicians	44	201	245
Nurses	134	611	745
Midwives	290	0	290
Lab. Scientists / Technicians	63	460	523
Community Health Officers (CHOs)	8	63	71
Community Health Extension Workers (CHEWs / JCHEWs	255	876	1129
Medical Records Officers /	86	370	456
Nutritionists	0	4	4
SURE-P Midwives	65	0	65
SURE-P CHEWS	92	0	92
Others	230	1380	1608
Supporting Staff	229	685	911

(Source: Zamfara State Ministry of Budget and Planning, 2006 &, Zamfara State, 2014 Zamfara State HMIS, 2015)

Funding for Maternal Health Programs in the State

Provision of funds is an essential requirement for improvement to be witnessed in the health sector in general which will then trickle down to the maternal health component of the sector. The WHO and UN recommendation and requirement for health sector budget is the allocation of about 15% of the total budget to the health sector. In Zamfara State the highest location to health sector was 13% in 2009 and the least was 4.5% in 200, however in the last five years preceding this study the sector received between 6-10% but with a very poor performance in terms of fund release. Most of the budgetary release was for overheads and capital expenditure and little was released for program aimed at improving the health of mothers directly as is shown below on the percentages for the MNCH programs. For example only 3% was released for capital projects in 2014 fiscal year (12). Though other capital projects were executed through the MDG s Projects and SURE-P projects across the state.

Consolidated Health Sector Budget Trend 2009-2014

YEAR	Health Sector Approved Budget	% of the State Budget
2006	2,615,176,253.00	11.71%
2007	1,764,912,996.00	4.53%
2008	5,672,843,518.00	11.34%
2009	7,675,843,013.00	13.14%
2010	6,048,494,552.00	9.03%
2011	6,006,572,691.00	10.75%
2012	7,510,853,744.00	6.22%
2013	7,265,734,401.00	6.49%
2014	9,993,730,457.00	8.70%
2015	6,229,000,000.00	12.55%

Table 6. (Source: Zamfara State Ministry of Budget and Planning, 2006 &, Zamfara State, 2014 Zamfara State HMIS, 2015)

The table above shows the budgetary allocation to the health sector from 2006 to 2014 and the percentage of state total budget for the years. The highest budgetary allocation to health sector in the last ten years was in 2009 which stood at 13.14% of the total budget and since then the health sector budgetary allocation dwindled to an average of 7-8% within the last five years.

Table 7: State budgetary allocation to MNCH programs

Year	Total State Health Budget	% of the Total Budget	MNCH Program Budget	% of the Health budget
2010	6,048,494,552.00	9.03%	50,000,000	0.82%
2011	6,006,572,691.00	10.75%	130,000,000	2.16%
2012	7,510,853,744.00	6.22%	85,000,000	1.13%
2013	7,265,734,401.00	6.49%	85,000,000	1.16%
2014	9,993,730,457.00	8.70%	61,800,000	0.6%
2015	6,229,000,000.00	12.55%	130,000,000	2.16%

Source: Zamfara State Ministry of budget and economic planning 2010-2015

The MCH allocation as a percentage of the health sector budget also in the last six years was less than 5% a closer take at the figures when compared with the total health sector budget the MCH programs only received about 2.0% in last five years preceding this study as shown in the table 5 below. This includes procurement of free drugs for all MNC and Obstetric care drugs through the State Sustainable Drugs Supply Scheme (SDSS).

Discussion

This study attempted to review some of the intervention programmes and policies that were put in place in Zamfara State northwest Nigeria to reduce maternal mortality and improved maternal health. The current maternal mortality in the state is still one of the highest in the region and in Nigeria when compared with the national average of 547 / 100,000 live-births according the NDHS of 2013 (1). The maternal mortality rate in Zamfara state can be linked to the several issues as outlined in the paper above. Though, socio-cultural issues still remains some of the major reasons for the high maternal deaths other reasons are none utilization of the health facilities during deliveries and preference for home deliveries by mothers (5). There are other institutional factors that are and may have contributed to the situations such lack of manpower and sufficient frontline health care workers in the communities and rural areas as evidence in the Human resource for health situation analysis made in this paper above (13).

Zamfara state has the highest poverty rate in Nigeria according to the United Nations global multidimensional poverty index 2015 with 91.1% and only 8.1% living above poverty line. The adult literacy rate for the state stood at only 26.2% (14, 15). The State is among those with high total fertility rate of 7.8 and lowest contraceptive prevalence rate of about 2% when compared to the national CPR of 15%. Though Zamfara State started the implementation of free maternal and child health care services about fifteen years ago since 2001, only about 5% of mothers were delivered at the health facility and only 6.5% delivered by a skilled provider and more than 80% of those who delivered do not come for post natal care to days after delivery (1). The poor hospital delivery is a clear indication of low hospital utilization for maternal health services with a consequent high maternal mortality in the state. The preference for home delivery and attendance by non skilled birth attendants at birth remains significantly high and a utilized option for most of the women in the state especially rural areas not only in Zamfara state but across northern Nigeria and some African states (16, 17).

The fees for service charged in most of the hospitals and clinics round the state despite the so called implementation of the free maternal and child health services at some designated facilities has contributed to the non utilization of the health facilities as it's an additional financial burden to the poor women and families in the state particularly those in the rural areas coupled with the cost of transportation to visit clinics at the urban centers (8, 5). Though over the years the state budgetary allocation to the health sector has tremendously increase in term of Naira or Dollar value but it remained stagnant in terms of total percentage allocation compared to the total state budget and revenue accrued to the state as it remained with 6-10% in the last ten years and only about 2% of the total

health sector budget goes to the MNCH programs (10). The health sector and MNCH funding has not been proportionate to the annual project population growth of the state at 0.5% with about 5% pregnant women and 22% women of child bearing age of the total Zamfara State population (16,18).

The health sector manpower in the state is therefore overstretched at the center mostly in the state capital, while there is a major gap in that critical area of the health sector which have been occasioned by incessant industrial strikes of the different health workers and labour unions in the state and nationwide due to non implementation and payments of the workers new salary structures such as the consolidated medical services salary (CONMESS) and health service salary (CONHESS) to other issues both at the national level by the Joint health Workers Union (JOHEASU). All these may have contributed to the high numbers of maternal deaths witnessed in the state. According to Okeibunor et al 2010, for every 1000 pregnant women there should be 100 Obstetricians or Gynaecologist meaning one specialist for 10 pregnant women. In Zamfara state the situation called for declaration of emergency in that direction as there are only eight Gynaecolists in the whole of the state at both the state and federal health facilities.

There are obvious gaps in policies, funding and political commitment with major underlying problems such as the scourge of poverty, weakened capacity of public institutions, low literacy levels and other entrenched negative health seeking behaviours, The safe motherhood programmes in Nigeria to a large extent have not made the expected impact given the amount of funds and resources injected into it especially in the northern part of Nigeria. Zamfara State and other northern Nigerian states need to redouble efforts for a meaningful improvement in maternal health situation in their respective states. Nigeria still has the worst record in Africa in reducing maternal mortality as illustrated by the prevailing maternal mortality rates, despite the country's huge oil revenue, resources and wealth (19).

It's clear that the shortcoming of most of these efforts put in place by most states government and even international donor partners in improving maternal health and reduction of maternal mortality are not coordinated and in most situations disjointed and vertical, with each state and donor or international partner working according to its mission and programme goal and vision. Though some of the partners may have similar objectives but due to lack of coordination and piece-meal approach the projects end of not actually reducing the problem of maternal death or making significant improvement with attribution to its activities on the observed improvement. Therefore, there is the need for integrated approached and replicable but also culturally appropriate programmes in states like Zamfara and other northern states with high maternal deaths and other poor health indices. There is the need for a critical mix of well-focused activities that are efficient, with local appropriate technology and effectively coordinated to lead to a synergistic improvement and better results, rather than a bit by bit approach in order to achieve significant reduction in maternal mortality (20). These must include giving a prominent place to coordinated, consistent and effective advocacy and social community mobilization efforts as well as dyadic behaviour change communication

activities that are context-specific, culturally and even religiously appropriate and implemented to address individuals, family / household and community factors that are associated with health-seeking behavior, morbidities and maternal deaths aiming at achieving the new sustainable development goals (SDG) targets (21,22,23).

Conclusion

The maternal mortality of 1049 / 100,000 live births may even be higher when all maternal deaths are measured and recorded in both the urban and rural areas of the state and in the north in general. Other socio-cultural and religious issues may also exacerbate the situation in Zamfara State as the state is more of rural than urban state.

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Appendix: Supplementary Tables 1-3:

Table 1: List of Intervention and Programmes by International Development Partners in Zamfara State 2005-2015

Name of International Donor/Partner	Implementing Partner(s)	Name of Project	Project Period	Intervention/ Target
Department for Foreign and International Development (DFID /UKAID	GRM Futures Group Consortium	MNCH2	2014-2019	Maternal Child Health- System strengthening
DFID / UKAID & Norwegian Government	Health partners International (HPI) Consortium	PRRINN / MN CH	2006-2013	Maternal, Newborn and Child health including Immunization
DFID / UKAID	HPI ,GRID& Partners	Women for Health (W4H)	2013-2018	Female Human Resource for Health- MCH
DFID / UKAID		State Accountability & Voice Initiative (SAVI)	2008-Date	State and local governance leadership, media and civil society on health and good governance
DFID / UKAID		SPARC	2008-Date	Good governance in Health and system strengthening
United States Agency for International development (USAID)	JHPIEGO / JHU Consortium	ACCESS	2006-2009	Maternal Child Health & Obstetric care
USAID	JHPIEGO / JHU Consortium	MCHIP	2009-2012	Maternal Child Health
USAID	EngenderHealth	ACQUIRE Fistula Care	2007- Date	Repairs and management of Obstetric fistula, Maternal health and family Planning
EU Prime	EU	EUPrime	2006-2011	Routine Immunization and System strengthening

USAID	Development Research & Projects Center (dRPC)	Leadership development Programme for religious and Traditional Leaders (LDT/LDP)	2008-2012	Advocacy for Maternal and reproductive health
Save the Children	Save the Children Nigeria	Community Management of Acute Malnutrition	2012-Date	Maternal Child health-Community Management of Acute Malnutrition (CMAM)
United Nations Children's Fund (UNICEF)	UNICEF Nigeria	WASH, GEP, Routine Immunization	Since 1996	Immunization, girl child education and rural water supply
World Health Organization (WHO)	WHO Nigeria	Maternal Child Health Program	Since 1996	Immunization, neglected tropical diseases, emergencies and MCH
Bill & Melinda Gates Foundation (BMGF)	Society for Family Health	Nigeria Governors Leadership Challenge Grant Management (NGLCGM)	2013-2014	Maternal child health and water supply
Pathfinder International	Pathfinder International (PI)	Maternal Child and Reproductive Health	2012-Date	Prevention of Postpartum Haemorrhage and Eclampsia(CCA-PPH)
USAID	Society for Family Health (SFH) & Association for Reproductive Health (ARFH)	Improved Reproductive Health in Nigeria (IRHIN)	2005-2011	Reproductive Health and Family Planning- Private sector Social marketing
USAID	Society for Family Health (SFH) & Association for Reproductive Health (ARFH)	Expanded Social Marketing Project in Nigeria (ESMPIN)	2011-Date	Reproductive Health and Family Planning-Private sector Social marketing

Table 1: Pogrammes and Interventions by International Donor in Zamfara State from 2005-2015

Table 2. Other Programmes and with direct implication to maternal health interventions in Zamfara State

Programme Name	Intervention	duration	Funding Source
Millennium Development Goals (MDGs) - Office of the Senior Special Assistant to President on MDGs (OSSAP)	-Debt Relief Gains / Conditional Cash Grants to States and LGAs- Construction, rehabilitation and repairs of primary health centers - Supply of hospital equipments and drugs - Capacity building and training of health personnel	2007- 2015	FGN / DRF
Subsidy Reinvestment Programme (SURE-P) – Maternal Child Health Program:	Conditional Cash Transfer to Pregnant Women attending ANC and hospital delivery in rural areas (N5, 000 equivalent to $25 for four complete ANC visits) Renovation, repairs and construction of primary health centers in collaboration with the National Primary Health Care Development Agency (NPHCDA	2011-2015	FGN SURE-P
Health System Development Project (I-II)	Health System Strengthening, Supply of hospital equipment and drugs and consumables Construction, repairs and renovation of primary health center across the state Training of health personnel	1999- Date*	World Bank
HIV / AIDS Development Project (HAP1-3)	Prevention and Control of HIV / AIDS, Treatment Care and Support to persons living with HIV / AIDS (PLWA), Prevention of Mother to Child Transmission of HIV / AIDS to pregnant women HIV Counselling and testing for pregnant women attending ANC	2005- Date*	World Bank

Roll Back Malaria (RBM)	Prevention and control of Malaria Malaria in Pregnancy- Intermittent Prevention of Malaria using SPs.	2006-Date	Roll Back Malaria/ Global Fund for HIV/AIDS,TB & Malaria (GFATM), RBM Partners & FGN
National Primary Health Care Development Agency (NPHCDA)	Midwives Service Scheme MSS- MDGs/DRF	2009-2015	provision of quality care and a skilled assisted delivery in PHCs

Table 3: Other Programmes with indirect implications for maternal health interventions

Programme Name	Intervention	duration	Funding Source
Community based Poverty Reduction Project (CPRP)	- Grants to LGAs and communities for poverty reduction and livelihood project - Construction, rehabilitation and repairs of primary health centers and schools and rural feeder roads	2005- 2009	African Development Bank (AfDB)
Community Social Development Project	Community based poverty reduction project which seeks to empower the poor by giving them resources, as grants, to implement and supervise community initiated multi-sectoral project	2009-Date**	World Bank
Health System Development Project (I-II)	Health System Strengthening, Supply of hospital equipment and drugs and consumables Construction, repairs and renovation of primary health center across the state Training of health personnel	1999-Date*	World Bank

International Fund for Agricultural Development Project (IFADP)	Community and rural sustainable project targeting poor communities and women empowerment in rural hard to reach areas. Construction, repairs and renovation of rural health posts and dispensaries.	2005-Date*	World Bank
National Fadama Development Programme (I-III)	Prevention and control of Malaria Malaria in Pregnancy- Intermittent Prevention of Malaria using SPs for Pregnant women	2006-Date	Roll Back Malaria/ Global Fund for HIV/AIDS,TB & Malaria (GFATM), RBM Partners & FGN
Sokoto Rima River Basin Development Authority (SRRBDA)- Federal Ministry of Water Resources: Parliamentarians Constituency Project		Since 1999-2015	Federal Ministry of Water Resources: Parliamentarians Constituency Projects
Universal Basic Education Commission(UBEC) Projects***	Construction, repairs and renovation of classrooms and primary schools across the state		Universal Basic Education Commission(UBEC) Federal Government of Nigeria
United Nations Children Emergency Fund (UNICEF) Girls Education Project	Gender based and girl-child education project in some selected LGAs		

*The State government is yet to contribute its counterpart funding for the program to effectively continue, program operations are likely to be hindered

**The Programme just recently got counterpart funding from the state government

***The UBEC programme has been having continued political will and support as it's never short of counterpart funding since 1999