

Assessment of maternity services available to clients in private health facilities in Sagamu Local Government, Ogun State

JO Aluko¹, AL Ajetunmobi² and MO Akinwaare¹

Department of Nursing, Faculty of Clinical Sciences, College of Medicine,
University of Ibadan and School of Nursing, Faculty of Science and
Technology, Babcock University, Ilisan Remo, Ogun State, Nigeria

Abstract

Background: The quality of health care provided in various health facilities is one of the factors implicated for unabated high mortality and morbidity rate frequently reported. Care rendered to women in private health facilities has not been given the deserved attention. Yet significant proportion of women access perinatal care services in private health facilities. This is evident in the available very scarce literature. Therefore, this study sought to assess the nature of maternity services available to women in the selected private health facilities and the extent to which such care is satisfactory to the users.

Methods: The descriptive survey was conducted in Sagamu Local Government Area (LGA). The study utilized a simple random sampling to select 20 out of 38 private health facilities within the LGA. All health workers providing nursing/midwifery care in each of the hospitals/clinics and all clients who were on admission or came on outpatient basis for treatment were purposively recruited for the study. The total sample was adopted based on relatively few numbers of clients and health workers patronizing and working in each of the private health facilities, respectively. A checklist was used to assess each selected private health facility, while two different structured questionnaires were used for data collection from clients and health workers. The data collected with the three instruments were analyzed using descriptive and inferential statistics. Thus, tests of association between variables of interest were done using Pearson chi-square; level of significance (*p-value*) was set at 0.05.

Result: The results reveal that 35% of health facilities had good building infrastructures; 50% had fairly good building infrastructure, while 60% had inadequate essential items for child delivery and management of a baby. Measurement and recording of blood pressure, abdominal palpation and fetal heart rate were commonly performed in the private

hospitals. In addition, 51 (73.9%) of the mothers received antenatal care during their last pregnancies in the facilities that were assessed but only thirty three (47.8%) returned to the same facilities for childbirth. More than half of the clients had a positive perception towards and expressed satisfaction with services in the hospitals. Close to 90% of the staff who provide nursing/midwifery care were auxiliary nurses.

Conclusion: The study reveals that the selected private hospitals/clinics were staffed with more number of quacks (auxiliary nurses) than qualified and registered nurses. Some of the facilities did not have the essential items and maternity related service. Therefore, stakeholders of health care industries should advocate enactment of legislation against quackery in nursing and midwifery practice in Nigeria. In addition, appropriate criteria involving should be put in place for establishment of private health facilities. Effective and efficient monitoring/inspection of established private hospitals/clinics should be promoted.

Keywords: Assessment, maternity, services, client, private healthcare facility, Local Government Area.

Abstrait

Contexte : La qualité des soins de santé dispensés dans divers établissements de santé est l'un des facteurs expliquant le taux de mortalité et de morbidité élevé et constant qui a été signalé. Les soins prodigués aux femmes dans les établissements de santé privés n'ont pas reçu l'attention méritée. Pourtant, une proportion importante des femmes accède aux services de soins périnataux dans des établissements de santé privés. Ceci est évident dans la très rare littérature disponible. Par conséquent, cette étude a cherché à évaluer la nature des services de maternité offerts aux femmes dans les établissements de santé privés sélectionnés et les mesures dans lesquelles ces soins sont satisfaisante aux utilisatrices.

Méthodes : L'enquête descriptive a été réalisée dans la commune de Sagamu. L'étude a utilisé un échantillonnage aléatoire simple pour sélectionner 20 établissements sur 38 dans la commune. Tous les agents de santé prodiguant des soins infirmeries / obstétricaux dans chacun des hôpitaux / cliniques et

tous les clientes admis ou en traitement externe ont été recrutés à dessein pour l'étude. L'échantillon total a été adopté sur la base d'un nombre relativement restreint de clientes et d'agents de santé fréquentant et travaillant dans chacun des établissements de santé privés, respectivement. Une liste de contrôle a été utilisée pour évaluer chaque établissement de santé privé sélectionné, tandis que deux questionnaires structurés différents ont été utilisés pour la collecte de données auprès des clientes et des agents de santé. Les données recueillies avec les trois instruments ont été analysées à l'aide de statistiques descriptives et inférentielles. Ainsi, des tests d'association entre les variables d'intérêt ont été réalisés à l'aide du test chi-carré de Pearson; le niveau de signification (*valeur p*) a été fixé à 0,05. **Résultat :** Les résultats révèlent que 35% des établissements de santé disposent de bonnes infrastructures de construction ; 50% avaient une infrastructure de construction assez bonne, tandis que 60% avaient des articles essentiels inadéquats pour l'accouchement et la gestion d'un bébé. La mesure et l'enregistrement de la pression artérielle, de la palpation abdominale et du rythme cardiaque fœtal étaient couramment effectués dans les hôpitaux privés. En outre, 51 (73,9%) des mères ont reçu des soins prénatals lors de leur dernière grossesse dans les structures évaluées, mais seulement 33 (47,8%) sont retournées dans les mêmes structures pour accoucher. Plus de la moitié des clients avaient une perception positive et étaient satisfaits des services fournis dans les hôpitaux. Près de 90% du personnel qui fournit des soins infirmiers / obstétricaux étaient des infirmiers auxiliaires.

Conclusion : L'étude a révélé que les hôpitaux / cliniques privés sélectionnés étaient dotés d'un plus grand nombre de charlatans (infirmiers auxiliaires) que d'infirmiers qualifiés et agréés. Certaines des établissements ne disposaient pas des articles essentiels et des services liés à la maternité. Par conséquent, les parties prenantes des industries de la santé devraient plaider en faveur de l'adoption d'une législation contre le charlatanisme dans la pratique des soins infirmiers et obstétricaux au Nigéria. En outre, des critères impliquants appropriés devraient être mise en place pour l'établissements des facilités de santé privés. Une surveillance / inspection efficace et efficiente des hôpitaux / cliniques privés établis devrait être encouragée.

Mots clés : *Évaluation, maternité, services, client, établissement de santé privé, commune.*

Introduction

Childbirth and its processes come with couples of health risk and concern which put the woman in the

light of need for medical intervention and assistance. About 75% of all maternal deaths are those associated directly and indirectly with some sort of complications during delivery and the week immediately after and this could be attributed to the inability to access adequate care [1].

The World Health Organization (WHO) estimates that about 580,000 women of reproductive age die yearly as a result of complications associated with pregnancy, and a large proportion of these deaths occur in Sub-Saharan Africa. This region has a maternal mortality of about 686 per 100,000 live births, which is one of the highest in the World. In Africa, one explanation for poor health outcomes among women is non-use of modern health care services by a sizable number of women of child bearing age. Regular medical checkup during pregnancy is important to reduce the risk of illness and death for the mother and child during pregnancy and delivery [2]

Available evidence suggests that the presence of skilled birth attendants during delivery dramatically reduces maternal mortality [3, 4]. This is illustrated by historical evidence from industrialized countries where maternal mortality was reduced by half following the introduction of professional midwifery care at birth, in the early 20th century. Improved access to hospitals after the Second World War further reduced maternal death rates, subsequently resulting in the impressive low levels currently recorded [5].

The use of maternity services in developing countries can be influenced by factors such as the socio-demographic characteristics (SDC) of women; culture; as well as availability and accessibility of the services [7, 8]. Various studies indicate an association between factors such as income, education, ethnicity, religion, culture, age, parity and decision-making power to utilize maternity services. There is paucity of quantitative research on care rendered to women and their newborns in private health facilities in Nigeria [9, 10].

Quality care is the totality of features and characteristics of an entity (product or service) that bear on its ability to meet stated and implied needs. Quality care is needed for many reasons including increasing financial investment, emphasis on accountability, cost effectiveness, public scrutiny and customer forums, high level of disapproval eroding client confidence; quality creates loyal customers [11].

Quality maternity services must be: **Appropriate** (meeting the individual's client needs).

This is the key element in quality measurement. Even if high levels are met with respect to all the other elements, if this is absent then the service has no quality; accessible (Being readily available to the client), **acceptable** (meeting the expectation of the client), **equitable** (being equally available to all clients), **effective** (being of real benefit to the client), **efficient** (provided without waste of resources) [12]. Each of these six features of the element is independent of the others; however they are all necessary to achieve high quality of healthcare service provided. The quality of the services provided by a hospital is measured by a comprehensive assessment of the structure of the hospital, process of health care delivery and the outcome of healthcare services [12].

Materials and method

The research descriptive survey design utilized a simple random sampling technique to study 20 out of 38 private health facilities in Sagamu Local Government Area (LGA), Ogun State, Nigeria. All clients and health workers in each private health facilities were purposively recruited for the study. The total sample used for the selection of the human participants in this study was based on the few numbers of clients and health workers patronizing and working in each selected health facility, respectively. Three research instruments (a checklist and two structured questionnaires; one for the health care worker and one for the client) were used for data collection in this study. The questionnaire for clients was divided into two sections: section 'A' elicited the socio-demographic information of the clients, while section 'B' focused on the obstetric information of the clients. The questionnaire designed for health workers has three sections: section 'A' sought for the socio-demographic variables of the health workers, section 'B' elicited for the perception of health workers on available maternity services, while section 'C' focused on health workers' obstetric practice. Data collection was done by a trained research assistant coopted from each of the selected private health facilities using the self-administered structured questionnaires and the checklists. Each of the administered questionnaires were retrieved and checked for completeness on the spot. The data were analyzed using both descriptive and inferential statistics. Thus, tests of association between variables of interest were analyzed using Pearson chi-square or Fisher exact test (for 2x2 tables). The level of significance (p-value) was set at 0.05. The findings were presented in frequency/percentage tables, figures as well as texts.

Results

Findings from the assessment of the selected private health facilities

The results from this study show that seven (35.0%) of the hospitals examined had structural facilities that could be said to be in fair condition, while other seven (35.0%) were in good condition. The remaining six (30.0%) were in poor condition. The facilities had attended to an average of fifty six (56) pregnant women each in the last three months. On the average, 28 deliveries were conducted in each hospital within the said period, while average 32 newborns were brought for child immunization (particularly BCG vaccine) in the private health facilities in the last three months.

Ten (50.0%) of the private hospitals had no infrastructures for management of child deliveries immediate care of the newborn. Similarly, 8 (60.0%) had inadequate essential items for child delivery and management of newborn after delivery (table 1).

Table 1: Availability of infrastructure and adequacy of essential items (N = 20)

Infrastructure for child delivery services	Frequency	Percent
Available	10	50.0
Not available	10	50.0
<i>Essential Items</i>		
Inadequate	12	60.0
Adequate	8	40.0

Nearly all the hospitals that were assessed performed clinical services such as blood pressure measurement and recording, abdominal palpation and recording always. However, only few of them sometimes (occasionally) had services such as tetanus toxoid immunization, STD diagnosis and treatment, weight measurement and recording and blood samples for haemoglobin or packed cell volume (PCV) to render to clients who visited their health facilities. Eight of the hospitals (40%) sometimes (occasionally) had screens to provide privacy for clients during physical examination. Table 2 presents regularity of the essential antenatal services rendered to women (clients) in the selected private health facilities.

It was discovered from the study findings that all the selected hospitals had an integrated antenatal service and 13 (65.0%) of them had integrated immunization services, while 12 of them (60.0%) have fragmented family planning services. However, none of the hospitals had voluntary counseling and HIV treatment (Table 3).

Table 2: Regularity of essential antenatal services in the private health facilities

Antenatal services in the health facilities	Sometimes n (%)	Always n (%)
Tetanus toxoid immunization	1 (5.0)	19 (95.0)
STD diagnosis and treatment	6 (30.0)	14 (70.0)
Blood pressure measurement and Recording	-	20 (100)
Abdominal palpation and Recording	-	20 (100)
Foetal heart rate detection and recording	-	20 (100)
Weight measurement and recording	-	20 (100)
Blood samples for haemoglobin or PCV	2 (10.0)	18 (90.0)
Urine samples for proteinuria and bacteriuria	1 (5.0)	19 (95.0)
Distribution of iron and folate supplements	-	20 (100)
Distribution of malaria prophylaxis	-	20 (100)
Screens for provision of during physical examination	8 (40.0)	12 (60)

Key: Sometimes = occasionally, Always = regularly

Table 3: Availability of maternity-related services in the private health facilities

Types of service	Not available n = 20	Fragmented n = 20 (%)	Integrated n = 20 (%)
Family planning service	-	12 (60.0)	8 (40.0)
Laboratory service	4 (20.0)	7 (35.0)	9 (45.0)
Immunization service	7 (35.0)	-	13 (65.0)
Antenatal care service	-	-	20 (100.0)
Voluntary counseling & treatment for HIV	20 (100.0)	-	-

Key: Integrated – Services can be accessed daily at all times in the health facilities.

Fragmented – Services can be accessed at a particular day and time of the week only.

Not available – Services are not rendered at all in the health facility

Socio-demographic information of the women (clients) using the private health facilities

The ages of the women who were users of the selected private health facilities ranged from 15 to 43 years; their mean age was 31 years \pm std. deviation. Out the 69 women studied, 41 (59.4%) were between 20 and 34 years old, while, three (4.3%) and 25 (36.2%) were teenage mothers (ages 15 – 19 years) and elderly mothers (35 years and above), respectively. Besides, 28 (40.6%) of them had secondary education as their highest level of education. Table 4 presents detailed information on the socio-demographic characteristics of the women.

Additionally, the past obstetric history of the women was captured in the study. As at the time of data collection, 13 (18.8%) of the women had given birth to one child each, while 56 (81.2%) had delivered more than once. A total of 32 (46.4%) utilized family planning services previously, while 18 (26.1%) booked for ANC in more than one

birthing centre. Thirty-three (47.8%) eventually delivered their babies in the selected private clinics/hospitals. It was discovered, 38 (55.1%) of the clients were satisfied with the level of care rendered to them but the remaining were not satisfied.

Biodata of the health workers

The ages of the health workers ranged between 20 and 45 years; the mean age of the population was 30 years \pm 6.2 standard deviation. Fifty percent were married. The professional profile of the health workers shows that 13 (21.7%) were registered nurses (qualified nurses licensed by the Nursing and Midwifery Council of Nigeria), while 39 (65.0%) were quacks who were fondly called 'auxiliary nurses' in Nigeria (Table 5).

Responses from the health workers showed that a good number of them (88.3%) claimed that the hospitals where they were working always rendered antenatal services such as tetanus Toxoid

Table 4: Socio-demographic variables of mothers (N = 69)

Sociodemographic variables	Frequency	Percent
<i>Age group (years)</i>		
15 – 19 years (teenage mothers)	3	4.3
20 – 34 years (young mothers)	41	59.4
35 – 43 years (elderly mothers)	25	36.2
<i>Religion</i>		
Christianity	35	50.7
Islam	31	44.9
Traditional	3	4.3
<i>Ethnicity</i>		
Yoruba	48	69.6
Igbo	8	11.6
Hausa	5	7.2
Others	8	11.6
<i>Marital status</i>		
Married	63	91.3
Divorced	5	7.2
Widowed	1	1.4
<i>Level of education</i>		
Informal	7	10.1
Primary	9	13
Secondary	28	40.6
Tertiary	25	36.2

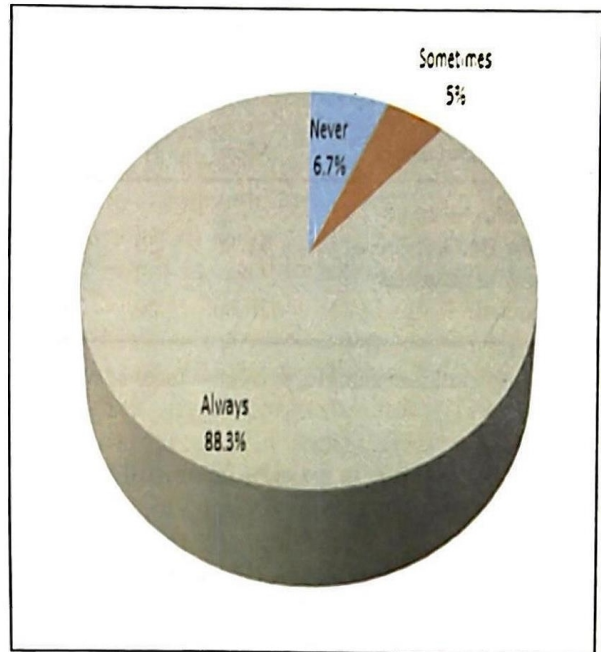
Table 5: The professional status of the health workers

Professional status	Frequency	Percent
Registered Nurse	13	21.7
Community Health Extension Worker	8	13.3
Auxiliary nurse	39	65.0
Total	60	100.0

immunization, STD diagnosis and treatment, blood pressure measurement, abdominal palpation and recording and fetal heart rate detection and recording rendered to the women (clients). However, 6.7% of the health workers confessed that the hospitals where they worked never rendered such services, while 5%

said that such services were sometimes (occasionally) rendered (Figure 1).

Out of the health workers studied, 51 (85.0%) confessed that there were no written obstetric guidelines in the clinics/hospitals to guide their clinical practice. In addition, 57 (95.0%) were not trained in Life Saving Scheme (LSS). However, the remaining who claimed they had LSS training demonstrated lack of knowledge of LSS just as their counterparts who never had LSS training. Similarly, 37 (61.7%) of the health workers confessed that it was not in the practice of the clinics/hospitals where they worked to test the serum bilirubin of the newborns following childbirth. Besides, 38 (63.3%) claimed that the private health facilities were used to rendering postnatal care to clients.

**Fig. 1:** Report of health workers on antenatal clinic services rendered in health facilities

Findings of the tested hypotheses

H_01 : There is no significant difference in the number of women who booked for antenatal care and the

Table 6: Comparison between population of women who booked for ANC and women who returned for childbirth

Paired samples statistics/correlations	Mean	N	Std. Deviation	Std. Error Mean	pv	Remark	Decision
Women who received antenatal care	56.00	20	82.906	18.538	0.06	NS	H_01 not rejected
Women who returned for childbirth	28.00	20	21.426	4.791			

Key: N = population sample, p-value = level of significance, NS = Not significant, H_0 = Null hypothesis

number of women who returned for deliveries in the selected private health facilities within the last three months.

The findings show that there was no significant difference in the number of women who booked for antenatal care and the number of women who returned for deliveries in the selected private health facilities within the last three months.; p -value > 0.05 (Table 6). Therefore, the null hypothesis (H_0) was not rejected. Although, the mean population of women who booked for ANC in the private health facilities were more than the mean population of women who returned to the respective private health facilities for childbirth but the difference was not statistically significant.

influence the quality of health care delivery services available to the client. Perhaps, this was responsible for the reported drop in population of women (clients) who returned to the hospitals where they booked for ANC initially for deliveries. Besides, since child immunization is always given on outpatient basis, the women population who brought their children for BCG vaccines was more than that of women who returned to the hospitals for childbirth. From the responses of the clients, majority would likely seek other health facilities they might consider better for services requiring admission. The unacceptable deplorable infrastructural condition of most private hospitals is likely to contribute to the annually reported maternal and neonatal mortalities in Nigeria [13].

Table 7: Comparison between population of women who returned for deliveries and population of women who brought their babies for BCG immunization

Paired Samples Statistics/Correlations	Mean	N	Std. Deviation	Std. Error Mean	p-value	Remark	Decision
Women who brought babies for BCG vaccine	31.85	20	38.356	8.577	0.023	S	Reject H_0
Women who returned for childbirth	28.00	20	21.426	4.791			

Key: N = population sample, p -value = level of significance, S = Significant, H_0 = Null hypothesis

H_0 : There is no significant difference in the number of women who returned to the private health facilities for childbirth and the number of newborns for child immunization in the respective health facilities.

The mean population of women who returned to the private health facilities for childbirth was fewer than the mean population of women who brought their newborns to the respective health facilities for child immunization (particularly for BCG vaccine). This was found to be significant; p -value < 0.05 (Table 7).

Discussion

Many (35%) of the private hospitals/clinics had structural facilities that could be said to be in fair condition, while 30% were observed to be in poor (deplorable) condition. Less than 40% of these health facilities were observed to be in good condition. For instance 50% of the private hospitals had no infrastructures for management of deliveries and 60% had inadequate essential items for immediate newborn care. To a very large extent, the condition of infrastructures of the health facilities would definitely

Meanwhile, the few private health facilities where administration of Tetanus Toxoids, diagnosis and treatment of STDs, laboratory investigations and provision of privacy were not rendered to women call for reproductive health attention. Therefore, initial and periodic inspection of private health facilities should strictly precede issuance and renewal of licenses for their operations, respectively.

In addition, the non-availability of voluntary counseling (VCT) /HIV screening in all the selected private hospitals should be an issue of serious concern to health workers and governments (at all levels). The omission of VCT/HIV screening by the private hospitals/clinics might be due to fact that this type service will not likely attract financial benefit to the establishments, more so, the services are usually provided by hospitals and centres owned by the government or non-governmental organizations (NGOs) at no cost. By implication, the selected private health facilities were rendering services that could be considered as inconsistent with quality health care that has the totality of features and characteristics of product or service that is capable of meeting stated and implied needs [14]. These

unacceptable ethical and legal implications pose numerous risks to staff, and clients, their relations and of course the larger society. Thus, availability of efficient VCT/HIV screening should be one of the criteria for establishment of any private health facilities designed to render maternity services.

Moreover, it is advisable and of course it should be mandatory for private health facilities that do not have qualified obstetrician and midwives not to attempt management of labour and childbirth for high risk mothers such as teenage and elderly mothers reported in this study. From the findings of the study, significant proportions of women were still not utilizing formal centres for ANC. This category of women has been implicated for contributing to persistent high rate of maternal and neonatal morbidities and mortalities in Nigeria and other developing countries. Meanwhile, what were responsible for non-utilization of ANC by over one-quarters of the women in the last pregnancy requires further study.

The use of quacks popularly referred to as auxiliary nurses by proprietors/proprietresses of private hospitals/clinics is a serious issue that requires urgent intervention if the sustainable development goals is going to be achieved optimally in Nigeria. Therefore, stakeholders are to seek for enactment and enforcement of appropriate legislations to stop the unethical and illegal practice. The educational and professional preparation of nurses/midwives is integral part of quality care.

Quality care has been defined as "the degree to which health services for individuals and population increases the likelihood of the desired health outcomes [14, 15]. Hence, the quality of personnel is part of the element and even the main determinant of this quality. It was discovered from this study that majority of the health personnel providing midwifery care to the clients were quacks with no formal clinical training to provide such level of care. This implies that these private hospitals/clinics had been rendering substandard and crude quality of midwifery care to women and their newborns. These facilities must have been exposing the clients to a very high level of risk and varying degree of malpractices capable of worsening the quality of care rendered to clients who attended these hospitals/clinics [15]. From the assessment of level of client's satisfaction with care they received from the health facilities, it was discovered close to 50% expressed dissatisfaction with care rendered to them. This might have been the reason for some of them booking for ANC in more than one health care

facility and why some did not access ANC in the last pregnancies. Besides, this might have been one of the reasons that compelled majority of the women not to return to the place of their initial booking for childbirth. Women who are not satisfied with services rendered are likely going to move from one health facility to another in search of care that guarantees them desired satisfaction [13].

Conclusion

The study reveals that the selected private hospitals/clinics were staffed with more number of quacks (auxiliary nurses) than qualified (registered) nurses. Some of the facilities did not have the essential items and maternity related services. Therefore, health care industries and relevant government and non-governmental agencies such as the ministry of health (MoH), the Nursing and Midwifery Council of Nigeria (NMCN) and National Association of Nigerian Nurses and Midwives (NANNM) should seek for enactment of legislation against quackery in nursing and midwifery practice in Nigeria. In addition, appropriate criteria involving infrastructures, human and materials resources should be put in place for establishment of private health facilities. The monitoring and inspection unit of the MoH should be strengthened to promote effective and efficient monitoring and inspection of established private hospitals/clinics. The potential users of private hospitals/clinics should be empowered through creation of aggressive awareness campaign for identification standard of care in health facilities.

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