Article

Maternal Health and Millennium Development Goal 5(MGD5): Discussing the *faux pas in* Nigeria

Journal of Management and Social Sciences

fountainjournalmanagementandss@gmail.com

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Abstract
The paper examines Maternal Health and recently concluded Millennium Development Goal 5(MGD5) and why there were obstacle(s) to its success in Nigerian society and the need for integrated interventions for the newly developed Sustainable Development Goals. Culture, poverty and lack of political will act as major causes for non-performance of the (MGD5). The main reasons for this among other things are low utilization of quality of maternal healthcare services, negative opinion of important referents, social, cultural, physical and economic barriers such as patriarchy, long distances, high transport and other indirect costs. The review therefore examined the existing level of maternal and child mortality/morbidity within the extant literatures/statistical abstracts and it was found out that inadequate health care/maternity centres, paucity of physicians and insufficient budgetary allocation were stumbling blocks to effective maternal health and success of MDG5. It is therefore suggested that government should make available functional primary health care facilities including maternity centres equipped with up to date infrastructures which would be funded equitably to facilitate patronage and easy access to both rural and urban residents. Effort should be made to retain trained professionals in all ramifications.

Keywords
Millennium Development Goal 5(MDG5), maternal health, culture contour, *faux pas*, infrastructure

Introduction

Maternal and infant mortality rates are of great concern to health managers in Nigeria and elsewhere in sub-African countries (Aluko-Arowolo & Ogundimu, 2015; Akiyode-Afolabi, 2014; National Reproductive Health policy and strategy Information – NHRFHSP, 2012; Feyisetan, Asa, Ebigbola, 1997). In Nigeria alone, maternal mortality rate reaches up to 3,200 women (number of mothers per 100,000 births dying within 42 days after the childbirth). Literally, every minute a woman dies from avoidable complications caused by

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pregnancy; it adds up to approximately half a million fatalities per year (Aluko-Arowolo & Ademiluyi, 2014; UNICEF, 2006). The case is more worrisome in Northern Nigeria, where the rate is even higher (NHRHSP, 2012). Improvements in key health indicators have been slow and Nigeria ranks second in the world among the countries with the highest child and maternal mortality: the under-five mortality rate is 201 per 1,000 live births (NHRHSP, 2012); maternal mortality ratio is estimated at 800/100,000 and 245/100,000 per live births in the North and south parts of Nigeria respectively ((Aluko-Arowolo, 2016; NHRHSP, 2012; Ogun Health Bulletin, 2009). The average rate of maternal mortality of 500/100,000 coupled with high rate of morbidity in Nigeria is one of the highest in the world (Anate, 2006; Harrison, 1997). The risk for maternal death (during pregnancy or childbirth) in sub-Saharan Africa is 175 times higher than the developed countries, and the risk for pregnancy-related illnesses and negative consequences after birth is even higher (UNICEF, 2006).

The reasons for the cases above among other things are variations in the culture and belief systems, uneven socio-economic and educational developments among regions and spatial variations in terms of availability, quantity and quality of facilities in both rural and urban areas of Nigerian societies. Others issues are human resources retention, development and management of those who have not migrated elsewhere for better opportunity. Including among these problems also was the poor budgetary allocation to health sector. All these posed very strong challenge and acted as very strong negative stimuli to the success of Millennium Development Goal 5(MGD5) on maternal and infant health. These challenges also impacted on the quality, effectiveness and efficiency of medical personnel and all round management of maternal health. I intend to expatiate on these subsequently. However, let us refresh our memories on what Millennium Development Goals are all about and specifically MDG5.

Millennium development goals are eight imperatives established by the United Nations in the year 2000 with measurable targets and clear deadlines to eradicate poverty, diseases and for improving the lives of the world's poorest people. The MDG5 on the other hand was on maternal health to improve maternal health in general and specifically to drive maternal and child deaths down by 2015.

Maternal Healthcare and MDG5

Maternal healthcare is the total health cares for pregnant mother and under five year's baby. It encompasses educational, social, and nutritional services and medical care during and post pregnancy. It is however, to be noted that, there are a variety of reasons while pregnant women and those of reproductive ages choose not to engage in proper prenatal and postnatal cares. Among these

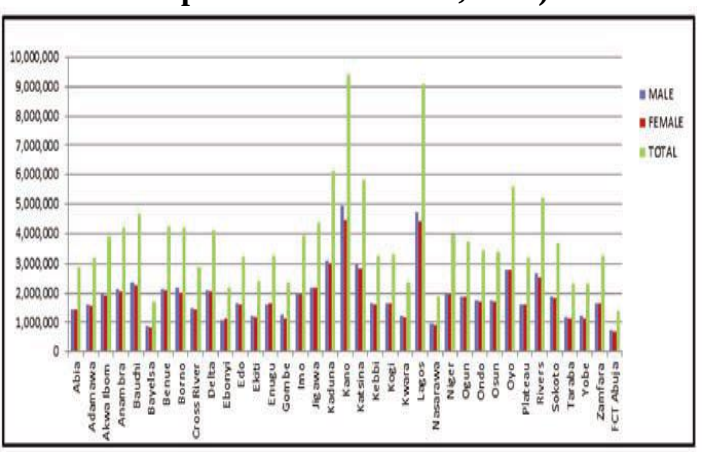
reasons are factors of culture, genetic and the levels of social, economic and political developments. That is, the nature (biology) and nurture (environment) play strong and decisive roles in maternal healthcare consumption. Whilst, culture on the other hand in every society is critical for the establishment of social order, health stability and coterminous with every aspect of human behaviours – including the means and methods of deployment of knowledge and technological knowhow to correct every form of health discontinuities – for instance maternal ill-health/disease (Jegede, 2010; Erinosho, 2006).

Stressing the argument further, cultural practices may be, in some cases the albatross against orthodox health care although, within the same culture there may be elixir to censure the antagonism tendency and cultural contours by putting premium on the strategies human development indices in social and economic terms (Adekoya & Aluko-Arowolo, 2012). Development in this sense is a state of growth or advancement in maternal health care utilization and accessibility. It is however, noted that paucity of human resources development, management and other indices of human development pose a major challenge to the implementation of health sector reforms and achievement of the health related goals (MDG5) in Nigeria (NHRHSP, 2012). This at same time engenders unwholesome practices towards modern health practices, including maternal ones. Mother's health in this context determines the health and survival of children.

Achieving Fifth Millennium Development Goal (MDG 5) then would have required socio-cultural and political will on the part of the government and enthusiastic participation of the people in pulling resources together for the needed development and suitable strategies for sustained maternal healthcare implementation.

Nigeria is depicted with the diagram below in **Figure 1.**

Figure 1: Population of Nigeria from 2006 National Census as adapted from NHRHSP, 2012)



Maternal health when viewed *vis-à-vis* the level of technology and health system in Nigeria, studies revealed that there is a positive relationship between the numbers of pregnancies a woman has had before, the total number of her children she is having presently and overall development of such children (Aluko-Arowolo & Ademiluyi, 2014). More of these children die before age of five (Tella, 2014; UNFPA 2010a). However, if there is high priority on overall socio-economic development and maternal health in term of budgetary allocation to emphasize primary health in its entire ramification many of the pregnancies may not be necessary. Each year over 162,000 women die from causes related to pregnancy and childbirth with sub-Saharan Africa countries **(**AbouZahr & Wardlaw, 2003**)** and neonatal deaths in developing countries account for 98% of worldwide yearly. These rates of incidence are precariously larger than any region of the world (WHO, 2006). Pregnancy also affects women's health because for each maternal death in Nigeria and elsewhere in developing world, more than 100 women suffer illnesses related to pregnancy and childbirth (Safe Motherhood).

Nigeria and other countries of Sub-Saharan Africa (SSA) are still reputed to have high maternal morbidity and mortality rates in the world (United Nations -UN 2003). The World Health Organization (WHO) in 1992, on the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) defines maternal mortality as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal deaths result from a wide range of indirect and direct causes such as low utilization orthodox health services, perceived low quality of maternal healthcare services in clinics, negative opinion of important referents, physical, social and economic barriers such as poverty, patriarchy tendency, long distances, high transport and other indirect costs. Indirect causes represent 20% of the total incidence of mortality - they are pre-existing or concurrent diseases that are not complications of pregnancy, but that are complicated during pregnancy or aggravated by it (WHO, 2006).

These causes are in this study refers to as the ***faux pas*** - I hope to return to this very soon - In addition, morbidity is the disease/illness suffered by the pregnant women during the period of pregnancy. Sometimes it may lead to disabilities and in some cases it affects the victims economic, social and fertility roles (World Health Organization-WHO, 2003). Maternal morbidity in Nigeria may be as a result of haemorrhage (34%), infection (10%), hypertensive disorders (9%) and obstructed labour (4%) (WHO, 2006). Others include anemia, malaria, placenta retention, premature labour, prolonged/complicated labour, and pre-eclampsia. The reasons include social and economic issues, such as poverty, ignorance, patriarchy norms – there is high proclivity of men taking decisions on major marital issues with little or no

consultation with the concerned wives, and other cultural beliefs and practices that are still being used to diminish the rights of women.

Studied have shown repeatedly that women in Nigeria and elsewhere in SSA suffer from twins problems of maternal mortality and morbidity due to low socio-economic status and cultural practices (Nwokocha & Okakwu, 2012; Nwokocha, 2004; Chiwuzie & Okolocha, 2001; Ashford, 2001). Stressing the foregoing further, Roberts (1996) quoting from the work of Fathala (1995) observed:

> …. a woman does not die as a result of post -partum hemorrhage, she died because she is suffocating from chronic under nutrition and anemia, lack of cheap and convenient transportation to take her to the tertiary health centre which is may be miles away. Lack of communication to inform the centre of the pending emergency, lack of available compatible blood transfusion and because she has born several children before and she is unaware of family planning (62).

The prevalence of health discontinuities, chronic disease and disability as determinants of life expectancy are noted to be as a result of one's culture, belief system, marital status, social support and social class (Marmot, Bobak and Smith, 1995). It was demonstrated that health status is directly related to the position in social class/occupation hierarchies. Social placement, social mobility and access to health care by the women folks in Africa and Nigeria in particular is the possible outcome of training/education or skill acquired through education and vocational training. However, a large number of women facing maternal death or morbidity are lowly placed within and between the social hierarchies due to poverty occasioned, especially by lack of sufficient income (Aluko-Arowolo, 2012; Jegede, 2010; Erinosho, 2006). And then to the *faux pas* that characterized maternal health and limited success recorded in MGD5.

The faux pas – Social Blunder

Faux pas is a French word which means a Freudian slip or blunder; a step taken wrongly in a social situation or context which may lead to embarrassment. An albatross against successful implementation of something worthwhile; it describes as incongruous to collective expectation of what ought to be as against what it is. But the blunder(s) in this sense in the context of maternal health could be as a result of social, political, economic, culture and environmental factors hindering or inhibiting accessibility to timely maternal healthcare and this often turn to be fatal to pregnant mothers (Aluko, 2009; Corin, 1995). In addition, there is a strong trend in rich and poor countries that appears to be related to development in technological and other medical advances, such as bio-technology, vaccine and drug innovations which is yet to

be fully embraced in Nigeria (Jegede & Fayemiwo, 2010). The disparity may be multidimensional and multifaceted, because what constitute health development as it were, in a plural society like Nigeria is relative and highly contentious. Not uncommon is the auspicious roles culture is playing, especially when religion is juxtaposed with culture to bring about value judgments on what constitute quality and unfettered health care for mothers (Aluko-Arowolo & Ademiluyi, 2014).

Of a particular interest is the conundrum of husband-wife relationship as defined by culture and the way the community perceive this relationship and Islamic injunction that forbids male doctors from treating female patients – this is particularly rife in the northern states of Nigeria, where majority are Muslims (Walker, 2001; Orubuloye & Ajakaiye, 2000; Jejeebhoy, 1998). These prescriptions are reflected in norms, values and customs (such as decision making at home), which dictate the behaviour, power and responsibilities of men and women. Because of this, in Sub-Saharan Africa countries alone, more than 250,000 mothers are dying yearly with many sustaining health impairment leading to disability as a result of unbooked (unregistered pregnancy) emergencies, inefficient and/or lack of maternity care (Harrion, 1997; Arkutu, 1995). Unbooked pregnancy is not only limited to decision making alone, disparity in access to health care also affects maternal health.

Disparity in Access to Health Care among Nigerian Population Groups

There are great disparities in health status and access to health care among different population groups in Nigeria. For instance, the under-five mortality rate in rural areas is estimated at 243 per 1,000 live births, compared to 153 per 1,000 in urban areas (UNICEF, 2006). While 59 percent of women in urban areas deliver with a doctor, nurse, or midwife, only 26 percent of women in rural areas do so (NHRHSP, 2012; Ogun State Health Bulletin, 2009). Furthermore, there are wide variations in health status and access to care among the six geo-political regions of the country, with indicators generally worse in the North than in the South (MDG Report 2004 in, NHRHSP, 2012). In 2014 budget allocation to health sector was six percent or N262 billion (or, 1.7billion USD), this is against N279 billion allocated in 2013. The usual template of allocation between rural and urban areas was still in place (Efe, 2013; Ademiluyi *et al*., 2009). The urban areas benefitted to the detriment of rural areas and little effort was on primary health including maternal health. The health sector in Nigeria is noted to be facing financial and human resources crisis (NHRHSP, 2012).

The Human Development Index (HDI) as a composite index that measures the achievement of countries in three basic dimensions of human development

in the areas of a long and healthy life, knowledge, and a decent standard of living have poor rating for Nigeria. There are also systemic deficiencies in the planning, management and administration of available personnel. The common outlooks are shortage of professional staff in the north and over supply in the south. Distribution of health workers is also skewed toward urban centres with acute shortages in rural locations. Coupled with these are staff recruitment regulations in some states with shortages of critically needed health staff that discriminate against non-indigenes (Efe, 2013; NHRHSP, 2012). Attrition of health professionals is becoming excessive due to brain drains. Brain drain is whereby professionals from the country of origin are "pushed away" due to unfavourable conditions of service to another country with alluring scenario that are "pull factors".

Migration of health care personnel to other countries is a current and serious issue in the health care system of the country, from a supply push factor, a resulting rise in exodus of health care personnel may be due to the unbearable working condition among other things. Furthermore, there are low level and discrepancies in salaries and other conditions of service for health professionals working at different levels and between states. The health worker force available was unevenly distributed (Efe, 2013; Ogundele & Olufimihan, 2009; Aluko-Arowolo, 2005) with urban areas of 30 percent inhabitants having the larger concentration of health workers, as against the rural areas with preponderance percentage of 70 percent having to do with lesser health workers (NHRHSP, 2012; Aluko-Arowolo, 2005).

In Nigeria of more than 160 million people, there are about 39,210 doctors and 124,629 nurses (This would translate to a doctor's ratio of 1: 4103 or about 30 doctors per 100,000 populations and 1: 1284 or about 100 nurses per 100,000 populations respectively) registered in the country, currently working (or not working or practicing at all - NHRHSP, 2012). Though, it is taken for granted that we cannot all be sick at the same time, but this figure is in gross contradiction of WHO standard ratio, which specifies ratios of doctors, nurses and environmental officer of 1: 600 patients, 1: 4 patients and 1: 8,000 people respectively (Ogun State Health Bulletin, 2009). Paradoxically, the insufficiency in the numbers of health personnel does not prevent the available ones from seeking for better pay and conditions of service elsewhere, where it is assumed that there are favourable climates.

Tables 1 below explicate this better:

Table 1: Nigerian Doctors Registered with the American Medical Association by Specialty

Specialty	Number	Percentage
Internal Medicine and sub specialties	1269	44
Surgery and surgical sub specialties	332	12
Family/General practice	281	10
Paediatrics	427	15
Psychiatry	187	7
Obstetrics and Gynaecology	161	6
Pathology/ Oncology	90	3
Radiology	35	1
Preventive Medicine	32	1
Others	41	1
Total	**2855**	**100**

Source: National Human Resources for Health Strategic Plan, 2012

The figures presented in the Table 1 above are for some health professional categories registered by Nigerian doctors. One notice with anguish that family/general practice Doctors in the following percentage (281/10%), paediatrics (427/15%) and obstetrics and gynaecology (161/6%) totalling 869 or 31% that are directly working on maternal health are particularly on attrition (NHRHSP, 2012). Many Nigeria doctors have emigrated to North America and Europe (as highlighted in table 1 above). This becomes clearer with the number of health professionals seeking for relocation outside the country as reflected in table 3 below. Before then table 2 is presented to situate the number of health personnel available for the whole population.

Table 2: Number of some Categories of Health Workers per 100,000 Populations in Nigeria

Staff Type	Number of Staff	Number of Staff/100,000 Population
Doctors	39,210	30
Nurses	124,629	100
Midwives	88796	68
Dentists	2,773	2
Pharmacists	12,072	11
Medical Lab. Scientists	12,860	12
Community Health Practitioners	117,568	19
Physiotherapists	769	0.62
Radiographers	519	0.42
Health Record Officers	820	0.66
Environmental Health Officers	3441	3
Dental Therapists	872	0.69

Source: National Human Resources for Health Strategic Plan, 2012

The figures presented in the Table 2 above are for some health professional categories registered by Nigeria's professional medical/health regulatory bodies as at 2006 (NHRHSP, 2012). They include health workers in both the private and public health sectors, and, very likely, health professionals who are not practicing in the country or may not be practicing at all. The figures include 215 expatriates. This suggests that there are considerable numbers of expatriates providing medical care support in the country. Though, it is taken for granted that we cannot all be sick at the same time, but this figure is in gross contradiction of WHO standard ratio, which specifies ratios of doctors, nurses and environmental officer of 1: 600 patients,1: 4 patients and 1: 8,000 people respectively (Ogun State Health Bulletin, 2009).

In most primary health centres in the local government areas in Nigeria, one doctor in most cases is employed to attend to myriad of health matters including maternal types (Ogun State Health Bulletin, 2009). These local governments are in most cases in the rural areas which may be in the desert as in the north axis or, swampy area in the south-south and in the south east with environmental degradation (Efe, 2013; Eghafona & Dokpesi, 2012; Jegede, 2012; Ajala & Aremu, 2012; Erinosho, 2006) with paucity of social amenities and health infrastructures. Paradoxically, the insufficiency in the numbers of health personnel does not prevent the available ones from seeking for better pay and conditions of service elsewhere, where it is assumed that there are favourable climates. Table 3 below explains this succinctly:

Table 3: Request for Registration with the American Medical Association by Specialty - for Verification by Nurses seeking Employment outside Nigeria in the Last Three Years

Country	**Years 2011**	**Years 2012**	**Years 2013**
United Kingdom	2500	2600	750
USA	2100	2050	650
Ireland	750	855	450
Australia	55	60	75
Canada	50	11	12
British Columbia	10	21	3
New Zealand	20	16	5
South Africa	15	16	6
Ghana	8	10	7
Botswana	4	5	10
Prince Ward Island	5	7	9
United Arab Emirate			
Total	**5619**	**5772**	**1967**

Source: National Human Resources for Health Strategic Plan, 2012

The figures presented in the Table 3 below are for some health professional categories registered by Nigeria's professional medical/health regulatory bodies as at 2006 but requesting for verification and seeking employment outside Nigeria in the last three years (NHRHSP, 2012). They include midwives and other nursing categories. The state of health care in Nigeria has been worsened by a physician shortage as a consequence of severe 'brain drain'. Many Nigeria doctors have emigrated to North America and Europe. In 2005, 2,392 Nigeria doctors were practicing in the United State of America alone, in United Kingdom the number was 1,529. In 2005, 2,392 Nigeria doctors were practicing in the US alone, in UK number was 1,529. Apart from movement between Nigeria and international communities, spatial issues can also be deciphered within the country.

Spatial and Cultural Contours against MDG5

Following from foregoing, healthcare system in Nigeria is replete with spatial variations in terms of availability, quantity and quality of facilities which often may not be apt to the needs of health care of the pregnant and nursing mothers within a particular epoch. Human resources retention, development and management is noted to pose a major challenge to the implementation of health sector reforms and achievement of the health related Millennium Development Goals in Nigeria (NHRHSP, 2012); as there is preference for urban areas than rural (Aluko-Arowolo, 2005). **C**ultural practices as it were, may be, in some cases the albatross against orthodox health care but at same time culture in this can be censured by sustained development in social and economic terms and political will. Many of these pregnancies may not be necessary, if there is high priority on overall socio-economic development and maternal health in term of budgetary allocation to emphasize primary health in its entire ramification.

Healthcare Financing in Nigeria: Suggestions for successful implementation of Sustainable Development Goals

The objectives of health financing are to make funding available, ensure appropriate choice and purchase of cost-effective interventions, give appropriate financial incentives to providers and ensure that all individuals have access to effective and efficient health services. State in all tiers of governments - Federal, State and Local Government - in Nigeria are the major health financiers through revenue accumulated through various forms of taxation and other resources. The share of the Federal Government from the federation account has created a lopsided budgeting allocation amongst three tiers of government and this has equally affected the allocation from lower tiers of government to the health sector.

Public health faculties in Nigeria are financed primarily by the public through tax revenue. Expenditures in the Nigeria health sector over the years is chronicled below, as it would be seen it is a chronicle of neglect (Jegede, 2010; Ademiluyi *et al.*, 2009; Erinosho, 2006; Owumi, 2002). Before the civilian government came into power in 1999, the annual government expenditures on health was $533.6 million in 1980 and afterward it was paltry $58.8 million in 1987. By 1999, however, there was noticed but, not significant increases in health expenditure in 2002 at $524.4 million and in the subsequent years. However, private and household expenditure on health between 1998 and 2002 was the highest with an average of 69.1% and 64.3%, while government expenditure in the same period was a paltry 20.6%. Donor's average expenditure in the period was 10.3%, while firms input were 4.9% respectively (NHRHSP, 2012). Budgeting and actual expenditure have been a contentious issues in health financing and achieving the Sustainable Development Goals of improved and sustained improved health care. This is not however, the problem, even if enough financial provision is made there is still a cultural norms of patriarchal to consider before decision is made on health consumption.

Household Structure and Decision-making on Maternal Issues

Apart from the level of development which is one of the factors that determines health seeking behaviour of maternal women, culture, gender roles and maternal health are inseparable. There is invidious intra power play within the family set up with wife's rights subjugated under the husband's own. In consequence of this, it sometimes leads to poor health communication between husband and wife (Salami & Taiwo, 2012). Sometimes these rights are abrogated out rightly, because in most cases women have no right of their own to determine when to have sex for instance, or when to prepare for the next baby. In a study by the Prevention of Maternal Mortality Network (PMMN) (1992) in Erinosho, (2006) which covers Nigeria, Ghana and Sierra-Leone, it was discovered that the patriarchal family system is impinging precariously on the health of the pregnant women. This is because women are made to be subjects and subordinates to their men.

In any case, this is one of the leading factors of unwanted pregnancies, unsafe abortion and maternal fatalities (Isiugo-Abanihe, 2003; Jejeehboy, 1998); which also heightens incidences of mortality, morbidity, child loss due to the problem of several pregnancies. The political process and procedure in this sense undermines the rights of women in taking decisions on reproductive issues including family planning (Gage and Njoku, 1994). This process alone has been traced to be one of the causes of low utilization of health services in Nigeria societies. The Gender Inequality Index (GDI) ranking in Africa as a composite measure that reflects inequality in achievements between women and men in the categories of reproductive health, empowerment, and the labour market did not favour Nigeria and other sub-Saharan Africa countries (WHO,

2012). This affects the extent to which women can make independent decisions in case of complications during labour and delivery period.

While the foregoing represents a more or less general understanding in the society, studies have examined the low utilization of formal health services *vis-à-vis* health of pregnant women as worst scenario of poor decision making (Samba, 1999). Household power structure at home alone in a way is an inhibition/hindrance to redressing unmet reproductive needs among women in Nigeria and Africa at large (Samba, 1999). Not only this, complications may be cumulative effects of religious practices, belief system and other cultural facts.

Religion and Maternal Health

Pregnant is regarded as a mystery in all societies of Africa and Nigeria is not an exception to this belief. Despite the illumination and understanding brought about by science and liberal art, this belief still persists. In this respect, religion tends to influence the belief system more especially reproductive ones are affected by religious affiliation in African societies (Akintan, 2001). In this sense what is known as religion in Yoruba land is constructed through what is explicable within the environment to explain the inexplicable. Thus, religion is devised to counteract environment problems, and as a response to certain diseases and life hazards, included in these are the ones associated with pregnancy. And this entails adhering strictly to certain religious prescriptions. This practice is particularly rife among the not-so educated and illiterate women in this province. Although historians of Christianity or Islam in Africa depict traditional religion as static, unchanging and evil, experience has shown that belief in the traditional religion is shared even among the Christians and Muslims (Isichei, 1983). For instance, Chinwuzie and Okolocha (2001) saw a correlation between traditional beliefs (and practices) and poor health status for pregnant women. Especially, foods taboo where food intake that would help the pregnant woman to be well off would be excused on the basic of religion and/or tradition. Islam on the other hand frowns at the practice of male doctors attending to female patients and vice-versa (see SMHFS, 2000). This idea without prejudices is counterproductive, to pregnant women especially where female doctors are not in adequate supply.

Concluding Remarks

Incidence and prevalence of disease of mother and child show that culture and development are very strong factors and significant indices of high mortality. Others are income, lack of facilities, derelict infrastructures, inaccessibility to the point of maternity by rural folks and inadequate maternal education. All these have deleterious impact and increase mother and child deaths in Nigeria and elsewhere in sub-Saharan Africa. The points therefore, that suffice from this review are thus: pregnant women are directed by certain socio-cultural and

environmental factors and inimical to the level of development required to have met with MDG5 goal. However, with an extensive health education, sufficient budgetary allocation, and change of some cultural elements which are contrary and militating against effective maternal health consumption; the inhibitions would be mitigated. Therefore, to attain the expected SDGs on health and enjoy robust maternal health, women and men too, are expected to act individually sometime in response to their health issues. Beyond this, there is the need for governments and other stake holders to understand the imperative of the SDGs and provide enabling environment for its success.

References

AbouZahr, C. & Wardlaw, T. (2001) Maternal Mortality at End of a Decade: Signs of Progress. Bulletin of the World Health Organization, PMC: Pub Med., 79: 32–34.

AbouZahr, C. & Wardlaw, T. (2003) "Maternal Mortality in 2000: Estimates Developed by WHO/UNICEF/UNFPA." Geneva: WHO.

Adekoya, J.A. & Aluko-Arowolo, S.O. (2012) Pregnancy Duration and Choice of Ante-Natal care in selected rural and mixed Urban areas of Ijebu. *Gender and Behaviour*. 10(1): 4370–4385.

Ademiluyi, I.A. & Arowolo-Aluko, S.O. (2009) "Overview of Health Infrastructure in Nigeria". *International Journal of Geography and Regional Planning*, 2(5): 104-110.

Ajala, A.S. & Aremu, D.A. (2012) The Peoples of Forest Region in Nigeria. In Jegede, A.S., Olutayo, O.A., Omololu, O.O. & Owumi, B.E. (Eds.). *Peoples and Cultures of Nigeria,* Ibadan: Department of Sociology, University of Ibadan, 51–63.

Akintan, O.A. (2001) The Introduction of Christianity and its Impact on Traditional Religion in Ijebuland: from 1892 to the Present. In Olubomehin, O.O. (Ed.), *The Ijebu of Western Nigeria: a Historical and Socio-Cultural Study,* Ibadan: College Press, 18-38.

Akiyode-Afolabi, A. (2014) Nigeria ranks second in maternal mortality. *The Nation* June 22, 8(2888).

Aluko-Arowolo, S.O. (Forthcoming) Rural Health in Nigeria. In Omotayo, A. & Yusuff, O.S. (Eds.). *Rural Sociology and Rural Development*. Faculty of Social Sciences, Lagos State University, Ojo, Lagos.

Aluko-Arowolo, S.O. & Ogundimu, A.O. (2015) Residence location and ante-natal healthcare utilization in selected public and private hospitals in Ijebu, South-Western Nigeria. Paper presented at 3rd World Conference on Psychology and Sociology (WCPS-2014) in Ephesus, Turkey on 6–8 November, 2014.

Aluko-Arowolo, S.O. & Ademiluyi, I.A. (2014) Maternal Healthcare in the Contexts of Culture, Infrastructure and Development in Pluralistic Nigerian

Society**.** *International Journal of Humanities and Social Sciences*, 5(4): 151-158.

Aluko-Arowolo, S.O. (2012) Culture and Health of People of Nigeria. In Jegede, A.S., Olutayo, O. A., Omololu, O.O. & Owumi, B.E. (Eds.), *Peoples and Cultures of Nigeria,* Ibadan: Department of Sociology, University of Ibadan, 229–240.

Aluko-Arowolo, S.O. (2005) Equity in Health and Federal Character Policy: A study in Rural-Urban Dichotomy. *Babcock Journal of Social and Management Sciences*, 4(1): 38-48.

Anate, M. (2006) "Women reproductive health in Africa, a continuing tragedy: an occasional Review". *Nigerian Clinical Review*, 7-14.

Arkutu, A.A. (1995) Health, women mother's health: an information guide. (2nd edition), FCI: New York.

Ashford, L. (2002) Hidden suffering: disabilities from pregnancy and childbirth in less developed countries, Washington, D.C. PRB.

Chiwuzie, J. & Okolocha, C. (2001) Traditional belief systems and maternal mortality in a Semi-Urban Community in Southern Nigeria. *African Journal of Reproductive Health*, 5(1): 75-282.

Corin, E. (1995) The Cultural Frame: Context and Meaning in the Construction of Health. In Amickil, B.C., Levine, S., Tarby, A.R. and Walsh, D.P. (Eds.). *Society and Health,* New York: Oxford University Press, 272-304.

Ashiru, O. (2006) "Nigeria health sector requires complete revolution". T*he Guardian of Nigeria Online* Publications, 30/08/2006.

Efe, S.I. (2013) Health Care Problem and Management in Nigeria. *Journal of Geography and Regional Planning*, 6(6): 244-254.

Eghafona, K.A. & Dokpesi, A.O. (2012) Peoples of the Mangroves. In Jegede, A.S., Olutayo, A.O., Omololu, O.O. & Owumi, B.E. (Eds.). *Peoples and cultures of Nigeria,* Ibadan: Department of Sociology, 35–50.

Erinosho, O.A. (2006) *Health Sociology*. Ibadan: Sam Bookman.

Erinosho, O.A. (1987) Health care and health care service in Nigeria ADF working paper, USA.

Feyisetan, B.J., Asa, S. & Ebigbola, J.A. (1997) Mothers' management of childhood diseases in Yorubaland: the influence of cultural beliefs. *Health Transition Review*, 7(2): 221-234.

Eschen, A. (1992) *Acting to save women's lives; report of the meeting of partners for safe motherhood,* Washington, D.C.: World Bank.

Gage, N.S. (1994) Njogu *Gender inequality and demographic behaviour in Kenya*, New York: The Population Council.

Geyndt, W.D. (1995) *Managing the quality of health care in developing countries*, Washington, D.C.: The World Bank.

Grange, A. (2012) Foreword to national human resources for health strategic plan 2008 to 2012, Abuja: Federal Republic of Nigeria Publication.

Harrison, K.A. (1997) Maternal mortality in Nigeria: the real issues. *African Journal of Reproductive Health*, 1(1): 7-13.

Isichei, E.A. *(*1983) *History of Nigeria*. Lagos: Longman.

Isiugo-Abanihe, U. (2003) *Male role and Responsibility in Fertility and Reproductive Health in Nigeria*. Ibadan: CEPAED.

Jegede, A.S. (2012) Introduction to Peoples and Cultures of Nigeria. Ibadan: Department of Sociology, 2–10.

Jegede, A.S. (2010) African culture and health (a revised and enlarged edition). Ibadan: Bookwright.

Jegede, A.S. (2002) Problems and prospects of health care delivery in Nigeria issues in political economy and social inequality. In Isiugo-Abanihe, U.C., Isamah, A.N. and Adeshina, J.A. (Eds.), *Currents and Perspectives Sociology*, Lagos: Malthouse, 212-226.

Jegede, A.S. and Fayemiwo (2010) Cultural and Ethical Challenges of Assisted Reproductive Technologies in the Management of Infertility among the Yoruba of South Western Nigeria. *African Journal of Reproductive Health*, 14(2): 115-127.

Jejeebhoy, S.J. (1998) Association between Wife and Fetal and Infant Death: Impressions from Survey in Rural Indian. *Studies in Family Planning*, 29(3): 300-308.

Lupton, D. (2000) The body, Medicine, and society. In Germov, J. (Ed.), *Second Opinion: Introduction to Health Sociology (*Revised edition), Melbourne: Oxford University Press.

Maguire, K. (2010) *Sociologies of Health and Illness.* E- Learning Databank www.medgraphics.cam.ac.uk/shield/.

NHRFHSP (2012) National human resources for health strategic plan 2008 to 2012, Abuja: Federal Republic of Nigeria Publication.

Nwokocha, E.E. & Okakwu, K. (2012) Maternal mortality among small-loan receiving women in selected Nigerian communities. *African Journal of Microfinance and Enterprise Development*, 2(2): 58-82.

Nwokocha, E.E. (2004) Socio-cultural factors affecting pregnancy outcome among the Ibani of Rivers State, Nigeria. An unpublished PhD thesis submitted to Department of Sociology, University of Ibadan, Ibadan.

Ogun State (2009) Ministry of Health Periodic. *Health Bulletin* 2007–2009 Edition.

Ogundele, B.O. & Olufimihan, H.O. (2009) Health care delivery services in selected state government hospitals in Oyo State, Nigeria. *Anthropologist*, 11(3): 181-187.

Owumi, B.E. (2002) The political economy of maternal and child health in Africa. In Isiugo-Abanihe, U.C., Isamah, A.N. and Adeshina, J.A. (Eds.), *Currents and Perspectives Sociology*, Lagos: Malthouse, 212-226.

Orubuloye, I.O. and Ajakaiye, D.O. (2002) *Health seeking Behaviour in Nigeria*. Ibadan: National Institute of Social and Economic Research (NISER).

Roberts, D. (1996) Reproductive issues and the empowerment of woman. In Erinosho *et al*. (Eds.), Ibadan: SSRHRN.

Salami, K. & Taiwo, P. (2012) People Culture and Health. In Jegede, A.S., Olutayo, A.O., Omololu, O.O. & Owumi, B.E. (Eds.), *Peoples and Cultures of Nigeria,* Ibadan: Department of Sociology, University of Ibadan. 229–240.

Samba, E.M. (1999) *Forward to Reproductive Health Information Package for Africa Region Regional Office in Africa*. Geneva: World Health Organisation (WHO) Publications.

Safe Motherhood Fact Sheet (SMHFS) (2000) *Safe motherhood: a community responsibility*. Lagos: World Health Organisation (WHO) Publications.

Tella, S.A. (2014) *The Affluent Society: can Africa make it?* The 66th Inaugural Lecture of Olabisi Onabanjo University, Ago-Iwoye, Nigeria.

UNFPA (2010a) Healthcare services in UNFPA assisted states of Nigeria. Lagos: Nigeria Country Office.

UNFPA (2010) *Reproductive Health and Fertility Issues in Nigeria's Rural Communities.* UNFPA Publications.

UNICEF (2010) The progress of Nigeria children, Lagos: UNICEF/Bureau of statistics.

Walker, M. (2000) High risk behaviour related to maternal health. *West African Journal of Medicine*, 20(4): 203-209.

World Health Organisation (2006) Country Health System Fact Sheet (Nigeria). www.afro.who.int/home/countries/fact_sheet/nigeria.pdf.

World Health Organization *Maternal Health*. World Health Organization. Retrieved 20 February 2012.