Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988

Olasupo O. Thompson, [1] ***Surajudeen O. Oladele***[2] ***& Olawale I. Yemisi***[3]

Abstract

In 1987, the World Health Organisation (WHO) launched the Safe Motherhood Initiative to combat the global maternal mortality crisis, with a particular focus on developing countries. The initiative sought to make childbirth safer and less burdensome by enhancing access to healthcare services, promoting skilled birth attendance, and strengthening maternal health systems. Nigeria, with its alarmingly high maternal mortality rates, became a significant focus of these efforts. This article examines the state of maternal healthcare prior to the introduction of the Safe Motherhood Initiative and evaluates Nigeria's response during 1987-1988. It explores the policies adopted, the challenges faced, and the socio-cultural factors shaping maternal health outcomes. Using a qualitative approach, the study critically analyses primary and secondary data from government efforts, healthcare infrastructure, and international collaborations. The findings reveal that maternal healthcare services in Nigeria were severely underdeveloped and insufficient before the initiative. However, Nigeria's response to the program

[1] Department of Peace and Development Studies, Institute of Communication and General Studies, Federal University of Agriculture Abeokuta Ogun State - ORCID: 0000-0002-2273-2152.

[2] Department of Peace and Development Studies, Institute of Communication and General Studies, Federal University of Agriculture Abeokuta Ogun State – ORCID: 0009-0007-6342-5902

[3]Department of History, University of Ibadan, Ibadan ORCID: 0000-0002-2817-9765

was largely passive, limiting its overall effectiveness and impact on the country's healthcare system. The study highlights both the achievements and limitations of Nigeria's engagement with the initiative and emphasises the importance of aligning national efforts with the broader global maternal health agenda.

Keywords: *Maternal Health, Nigeria, Safe Motherhood Initiative, Mortality*

Introduction

Women play important roles in the society. Some of such roles are childbirth and childcare. The birth of a child is one of the most significant aspect of a woman's life. Practices associated with this processes are therefore important to the woman's health and wellbeing as well as the overall outcome of her pregnancy (Dundes, 1987). By the beginning of the nineteenth century up till the middle of the twentieth century, the fear of death in childbirth was already known among most women who were about to go through the process in Europe (Chamberlain, 2006). Childbirth was seen as dangerous to women, even with the advancement of sciences in the western world until well into the twentieth century (Loudon, 2000; Drife, 2002).

In Africa, and among the Yoruba to be specific, the fear of death during childbirth resonates when a woman is about to give birth as well. A professor of public health, Lucas (1990) once described pregnancy in many countries in Nigeria as the most hazardous entreprise. For instance, among the Yoruba, a woman, after safe delivery is generally greeted, "*Eku ewu omo*"[1] — We felicitate with you over the risk through childbirth. This challenge as well as responsibilities of women is aptly put by Mojekwu-Chikezie (2012) when she stated that the duties of mothers begin long before they officially become mothers and then comes the pivotal day of delivery, marked by the indescribable agony of labor. She furthered that it's no surprise that more women lose their lives to pregnancy-related complications daily than soldiers do on the battlefield. Ultimately, while pregnancy, childbirth, and

Olasupo O. T, Surajudeen O. O. & Olawale I. Y. (2025) Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988. *Lajohis* 7 (1)

motherhood are uniquely women's experiences, men are not exempt from sharing in the responsibilities they entail.

It was the act of preventing these sad experiences in childbirth that led to the introduction of maternal healthcare. Though it was done by the women or mothers in the houses and homes of the patients, with time, it developed into a profession. Maternal health has long been a critical area of concern for global health organisations, particularly in developing countries where maternal mortality rates remain alarmingly high. In the late 1980s, recognizing the urgent need to address this crisis, the World Health Organisation (WHO) launched the Safe Motherhood Initiative. Introduced in 1987, this global campaign aimed to reduce maternal mortality by promoting comprehensive strategies for maternal care, including safe childbirth practices, improved prenatal and postnatal care, and increased access to trained medical personnel. At the core of the initiative was the promise of making childbirth not only safer but as painless and humane as possible.

Nigeria, with its significant maternal health challenges, became a focal point for these international efforts. At the time, the country faced one of the highest maternal mortality rates in the world, exacerbated by inadequate healthcare infrastructure, cultural practices, and limited access to modern medical facilities. As WHO mobilised global attention towards maternal health, Nigeria was called upon to take decisive action in implementing these international recommendations. This article examines Nigeria's response to the WHO's Safe Motherhood Initiative between 1987 and 1988, exploring the strategies adopted, challenges faced, and the broader impact on maternal healthcare in the country. A lot of studies have focused on the Safe Motherhood initiative globally.

This paper therefore examines the World Health Organisation's Safe Motherhood Initiative on Maternal Health and Nigeria's Response, 1987-1988. The paper asks the following questions: What was the state

of maternal healthcare before the introduction of the Safe Motherhood Initiative in 1987? What led to the introduction of the Safe Motherhood Initiative and how did Nigeria responded? What was the implication of Nigeria's repose to the country's maternal healthcare? By analyzing the intersection of global maternal health policies and Nigeria's local context, this study sheds light on the effectiveness of the Safe Motherhood Initiative in addressing the complexities of childbirth in a developing nation. To what extent did Nigeria align with the initiative's goals, and how did this early intervention shape maternal health outcomes in the years that followed? The paper relies on primary and secondary sources. The primary sources are majorly government records, oral interview and archival documents of the WHO retrieved from the Yaba Medical Library. This was complemented with other secondary materials such as books, thesis, journals and newspapers.

Literature Review

There have so many works on safe motherhood initiative. Abouzar (2003) observed that historically, the United States experienced maternal mortality having recorded about 700 maternal deaths for every 100,000 births which only declined in 1950, as a result of the advent of technologies and supply of drugs as well as the political will. This work adds to knowledge production on maternal mortality and morbidity as a global phenomenon before the advent of western medicine and how the introduction of technological advancement changed this situation. Hope (2010) asserts that the WHO, since inception in 1947, continued to play vital roles as an actor in the field of public health and international public health policy. While her work helps to understand the history and roles of the body in public and maternal healthcare, she did not state the role of the international organisation in women's healthcare-- the Safe Motherhood Initiative.

With the introduction of the Safe Motherhood Initiative, one would have thought that, maternal morbidity and mortality would drastically reduce. Hunger Note (1987), attest to the aim the initiative aimed to play in addressing maternal mortality and morbidity. Though, it

Olasupo O. T, Surajudeen O. O. & Olawale I. Y. (2025) Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988. *Lajohis* 7 (1)

addresses the issue of women's productive health capacity, it did not reveal how Nigeria or the people of Abeokuta responded to the global policy. Mahmoud Fatallah, (1998) stated the objectives of the Safe Motherhood Initiative to reduce maternal mortality by 50 percent by 2000, but that it failed as a result of lack of resources. It furthered that its failure to also examine how it affected developing countries which were in debt crises as a result of the economic policies introduced by the world powers was also part of its weaknesses. Maine and Rosenfield (1999) argued that the SMI failed not as a result of lack of resources, but due to the lack of strategic focus on the part of Governments. The significance of the work to this thesis, is that it shows some factors responsible for failure or inability to implement the initiative. However, adequate attention has not been given to the implementation of the initiative in Nigeria.

Maternal Healthcare in Nigeria before the Safe Motherhood Initiative

Maternal healthcare is a long held practice and profession in pre-colonial Nigeria. There were different types of healthcare practitioners who focused in various health and medical issues during the pre-colonial era. Some of the practitioners were domiciled in their places of popularity or services while others moved from one place to another just like traders (alajapa) advertising and offering their services to those who needed them. Aside the experts, some patients also traveled round to seek for the assistance of renowned herbalists and native doctors for powerful charms and medicines. Some native doctors also moved from communities to communities offering their services to interested patients. These professionals vary across different societies. As Burke-Gaffney (1966) stated that these traditional healers primarily relied on methods such as suggestion, incantations, charms, and unconventional

remedies. However, through their understanding of herbs and roots, they often stumbled upon, perhaps by chance, several effective indigenous treatments adding that some of these remedies have since been scientifically validated and proven to be effective in addressing conditions like diarrhea and certain intestinal parasitic diseases.

However, the contact between the Europeans and the indigenous people of pre-colonial Nigeria through the European Explorers and Missionaries changed the cause of the health system. The advent of the Christian missionaries in the mid-19th century brought about a change and introduction of western healthcare system. Indeed, most of the missionaries were not skilled medical practitioners; but with time, they either stared learning from medical manuals or brining at least a medical personnel or healthcare practitioner such as midwives or nurses. For example Father Jean Mariere Coquard who introduced western maternal healthcare services in Egba was not a medical doctor but he relied on a medical manual which helped him tremendously (Thompson, 2021). The rationale for medical missions was anchored on the belief that one can win the indigenes through medicalisation and goodwill and not just to propagate the word.

With the advent of colonialism, the British colonial government which was initially reluctant to provide western healthcare to women. For instance, Lady Oyinkansola Abayomi had to protests to the colonial office that a maternity centre was needed in Lagos colony. Nevertheless, with time, the British colonial government began to have a change of heart by first, collaborating with the existing missionaries and later setting up its own hospitals and healthcare centres. Nevertheless, these facilities were inadequate to address the teeming population who were now interested in patronizing western healthcare facilities together with the indigenous health institutions. Some of the factors that led to the undermining of traditional medicine and its subsequent neglect was the missionaries' association of traditional medicine with witchcraft, Satanism, and evil and the imperial nature of the British colonial administration which wanted to enforce its health ideology on the citizenry.

The British Colonial government made some frantic efforts to develop the health sector in the country having met a system different from the western styled healthcare. The indigenous people had its own folk medicine and ways of addressing pregnant and nursing mothers. These ways were however condemned by the colonialists. By introducing the western styled medicine, healthcare became expensive, elitists and inadequate as there were no healthcare facilities to reach the rural dwellers. While the British may have had some genuine reasons to improve the health sector, no doubt that arrogance of the superiority of its healthcare as well as its aim to impose and imperialise the sector was another motive.

Nevertheless, by the time it left Nigeria after colonialism, the healthcare facilities were still grossly unavailable to the entire people and the personnel were still inadequate.

Table 1: Registered Medical Personnel/ Doctor: Patient ratio, 1960, 1970 and 1979

Year	Registered Medical Practitioners	Doctor: Patient ratio
1960	1, 079	1:47,330
1970	2, 683	1:24,530
1979	6, 584	1:12,550

Source: Fourth Development Plan, Chapter 20, 272-293

In many parts of Africa, there was usually one doctor for more than 200,000 people (Falola, 1980). In Nigeria, Chad and Niger, for instance, the ratio was one doctor for 30,000, 73,460 and 56,140 people respectively (Ibid). This had a huge implication on the general well-being of the citizenry on the continent as shown in the table below:

Table 2: Population data: Selected African countries and developed countries, 1978

Region/ Country	Population Estimate mid-1978 (millions)	Birth rate (per 1000)	Death rate (per 1000)	Rate of natural increase (asnnual %)	Infant Mortality rate	Life expectancy at birth (years)	Urban population (%)	Per capita Gross National Product (GNP) (US$)	Physical quality of life index
Africa	436	46	19	2.7	147	46	25	440	----
Egypt	39.6	38	12	2.5	108	53	44	280	42
Nigeria	68.4	49	21	2.8	157	41	18	380	25
UK	56	12	12	0	14	72	76	4020	94
USSR	261	18	9	0.9	28	69	62	2760	91
USA	218	15	9	0.6	15	73	74	7890	94
Europe	480	15	10	0.4	20	71	65	4420	----

Source: 1978 World population data sheet (Washington, DC: Population Bureau, 1978) From an Excerpt from Toyin Falola, "Economic and Social Development in contemporary Africa." In, Richard Olaniyan ed. *African History and Culture,* (Ibadan: Longman, 1980), 112

Table 2 above shows that the life expectancy for Nigeria was barely half of what people in developed countries enjoyed. However, a significant number of deaths were attributed to poor sanitary conditions, among other factors (Bradley, 1978). Thus, Falola (1980) asserts that the health programmes in Africa were not sufficient to tackle the numerous health challenges due to lack of drugs, inadequate hospital facilities, and avoidable endemic diseases. He attributed the

Olasupo O. T, Surajudeen O. O. & Olawale I. Y. (2025) Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988. *Lajohis* 7 (1)

high infant and child mortality rate to poor hygiene. He succinctly puts it as follows:

> Drugs and hospital facilities are scarce. Public health programmes have not yet really tackled the major health problems. Malaria, polio, cholera, measles, and tuberculosis still take far too many lives in these countries. Infant and child mortality rare high due largely to poor hygiene in the home and lack of vaccination; malnutrition makes children more vulnerable to disease, with the result that many die of illnesses which for children in the developed countries are merely minor ailments. (1980:119)

The above summarises the public health condition of the country, which reflects on the mortality rate of the children. Consequent upon which reflected on vital demographic data of the population as seen below:

Table 3: Selected Demographic Data on Nigeria 1950-80

Period	Crude Birth rate Per (000)	Life Expectancy		Crude Death Per (000)
		Males (Years)	Females (Years)	
1950-55	-	33.5	36.5	-
1955-60	-	36.0	39.1	-
1960-65	50.0	38.5	41.6	25.0
1965-70	49.6	40.9	44.1	24.0
1970-75	49.3	43.4	46.6	22.7
1975-80	49.2	45.9	49.2	20.7

Source: Fourth Development Plan, 283

Table 3 shows the demographic data on Nigeria as related to crude birth, life expectancy. Rosenfield and Maine (1985) reported that

though there had been some interest in improving maternal and child health (MCH) in developing countries, the interest was not strong enough to adequately tackle the menace during the period. This was because the causes of maternal mortality remained neglected by professionals, policy makers and politicians (Ibid). This neglect manifested in the increase in the rate of women dying from pregnancy-related causes as seen below:

Table 4: Estimated Lifetime Chance of Dying from Pregnancy-Related Causes, by Region, 1975-84

Region	Lifetime Chance of Maternal Death
Africa	1 in 21
Asia	1 in 54
South America	1 in 73
Caribbean	1 in 140
North America	1 in 6,366
Northern Europe	1 in 9850

Source: Calculated by Dr. Roger Rochat, Emory University School of Medicine, in Ann Starrs, "Preventing the Tragedy of maternal Deaths," 13.

Table 4 shows the lifetime chances of dying from pregnancy related cases in Africa, including Nigeria. In contrast, other region including Asia which was almost at par in terms of development with Africa even fared better. It was however further exacerbated by the dwindling economy arising from the oil fall and international economic interventions. All these had serious implications across the country including Abeokuta. The most common of these impacts in Abeokuta were malnutrition and mortality.[2]

Safe Motherhood Initiative and Nigeria's Response

A WHO study in early 1987, showed that half a million death from pregnancy related case occurred each year with millions of women permanently disabled (Hunger Notes, 1987). There was a wide disparity between developed and developing countries Roth and

Mbizvo, 2001). It was observed that mothers in low income countries were 50 to 100 times more likely to die in pregnancy and childbirth complications than others in affluent countries (Hunger Notes, 1987). The World Bank Adviser on Women in Development, Economist Barbara Herz, averred that the poor healthcare and high maternal mortality rate was due to the low budget allocation on healthcare which was estimated at a cost of $2.00 per capita or even less to provide the essential health services in most developing countries annually (Ibid).

The product of the study came to fruition in February 1987 at the International Conference on Safe Motherhood held at Nairobi, Kenya. It was sponsored by the World Health Organisation, the World Bank and the United Nations Fund for Population Activities as well as support from the United Nations Development Programme with representatives spanning 37 countries, seven bilateral aid agencies and 14 non-governmental organisations along with the UN agencies. Dr. Halfdan Mahler in his opening remarks asserted that,

> [Maternal mortality] is a neglected tragedy, and it has been neglected because those who suffer from it are neglected people, with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants, and above all, women (Starrs, 1987:4).

Participants at the conference discussed the causes of maternal mortality from two general perspectives. On the one hand, women's low status and poverty were often at the root of their poor health, high fertility, and lack of access to essential health care. On the other hand, studies indicated that three-quarters of the maternal deaths in developing countries were caused by one of five common obstetric complications: haemorrhage, obstructed labour, infection, eclampsia,

and abortion (Ibid). Hence, the Conference hinged on the solution to the challenges with the three under listed factors.

Firstly, that motherhood should be made safe; secondly, that the world could afford to make it safe; and third, the need to build up and sustain the political commitment, and to generate resources necessary to make motherhood safe (Fathalla, 1998). Starrs (1987) observed that participants at the conference noted that most developing countries allocated less than 20 percent of their health budget to maternal and child healthcare programmes and the majority of that 20 percent was invested in child health programmes. They then called attention to this problem, in order to create the awareness that something could and should be done to redress the situation by starting with the political will and commitment of heads of states and governments (Ibid). Thus, the President of the World Bank, Barber Benjamin Conable, asserted at his opening address of the Initiative that the WHO was not involved to just publicise a problem but that the organisation was on ground to attack it, to save lives, and to build better ones. He furthered that the world leaders could make the conference the beginning of a new commitment to common decency and common sense where women's health is basic to women's advancement in all fields of endeavors and that as a mother's health is the bulwark of her family, it is the foundation of community and social progress. He added that by working for Safe Motherhood, the leaders were working for stealthy development on all fronts. He further outlined a three-tier approach to curb maternal mortality. These were, stronger community-based healthcare, stronger referral facilities and an alarm and transport system to bring expectant women at risk within a survival time-frame to the facility (The Guardian, 1987). Following the global rise in the AIDS/HIV epidemic, the WHO inaugurated the 'Strategy for Health for All by the Year 2000' in May 1987 (WHO, 1987). The Organisation stressed the importance of the decisions adopted by the non-aligned and other developing countries, as expressed in the resolution on the implementation of the Strategy and technical cooperation among developing countries (Ibid). It further requested the Director-General to mobilise support for these

Olasupo O. T, Surajudeen O. O. & Olawale I. Y. (2025) Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988. *Lajohis* 7 (1)

and other member countries for the implementation of their own tasks for achieving the goals of the Strategy, and encouraged technical cooperation among them, urging the nations to keep the Health Assembly informed of the progress made (Ibid).

It also set out roadmaps on how to implement the Strategies of the Nairobi Conference, so as to reduce the state of maternal morbidity and related mortality in many developing countries, which accounted for about 50 percent of all deaths in women of childbearing age (Ibid). It further aimed to reduce maternal mortality by 50 percent by the year 2000 (Family care International, 2007). It then urged member states to among othefr things prioritize improving women's health and reducing maternal mortality and morbidity by implementing effective primary healthcare, ensuring adequate nutrition and health programs for girls from infancy to adolescence, and supporting family planning initiatives within the primary healthcare framework which included making family planning services accessible to prevent unwanted or high-risk pregnancies. He added that there was need to provide comprehensive prenatal care with efficient systems for early detection and referral of high-risk pregnancies and guarantee the presence of properly trained personnel during childbirth for all women. He added strengthening referral systems and oversight mechanisms in maternal and child health and family planning to effectively manage obstetric emergencies and above all fostering coordination between health and other sectors to enhance women's education and nutrition and create supportive social structures during pregnancy, delivery, and the first year postpartum (2007: 20-23).

In order to address the challenges of poverty and malnutrition which arose as a result of the Structural Adjustment Programme (SAP), the United Nations Children's Fund (UNICEF), revealed that the policy had negative impacts on nutrition, food security (Heidhues, and G. Obare, 2011), and conditions of the vulnerable groups in developing

nations (UNICEF, 1987). It therefore, advised the International Monetary Fund (IMF) to implement the economic measures with a human face (Cornia et al 1987).

Nigeria's Response to the Safe Motherhood Initiative and Implication

There are no doubts that the World Health Organisation's Safe Motherhood Initiative (SMI) comes with lots of benefits for women, maternal healthcare and health system generally. However, Nigeria did not implement the Safe Motherhood Initiative. The non-implementation of the Safe Motherhood Initiative had implications for the nation. It posed serious challenges to the development of maternal healthcare services in the country and particularly in Abeokuta. By the time the World Health Organisation came up with the Safe Motherhood Initiative, which would have helped improved lots of women in the country and Abeokuta in particular, the FG did not implement it. Thus, the failed, partial or poor implementation of most of these WHO interventions had serious implications on the conditions of pregnant women, nursing mothers and their infants across the country. For example, Every Woman (1990) observed that while some reports revealed that about 100,000 women died each year in pregnancy and childbirth related issues in Nigeria, other sources revealed that it was 75,000 (Concord Newspaper, 1990; Fatuase, 1990; Chukudebelu, 1990). The situation in Nigeria was described as so sad that a woman died every 10 minutes from pregnancy and child delivery related complications (Every Woman, 1990). The then president of Society of Gynaecologists and Obstreticians of Nigeria (SOGON), Professor Wilfred O. Chukudebelu, argued that one of every 260 women of childbearing age died in pregnancy and for every one that died, 20 more were disabled or diseased, sometimes to the extent that they never bore children again (Chukudebelu, 1990). He advanced that the Nigerian woman had a one in 24 chance of dying during pregnancy or childbirth and this chance confronts her an average of 6 times in her lifetime while her Western counterpart had one in 17,000 chances of dying in

Olasupo O. T, Surajudeen O. O. & Olawale I. Y. (2025) Ensuring Painless Childbirth: World Health Organisation's Safe Motherhood Initiative on Maternal Healthcare and Nigeria's Response, 1987-1988. *Lajohis* 7 (1)

pregnancy which was a fate that confronted her on an average of only twice in her lifetime (1990: 6).

Though records of Abeokuta were unavailable by the end of 1987, no doubt that a leaf could not have fallen farther from its tree. Although in 1988, the Federal Government of Nigeria inaugurated the National Health Policy and Strategy to Achieve Health for all Nigerians by the year 2000 and beyond (Thompson, 2021), it was little, too late and it could not be compared to the Safe Motherhood Initiative which was specifically introduced to address the peculiarities facing pregnant women, nursing mothers and their infants who died in their droves in developing countries as a result of high rate of maternal and infant mortality in the country.

Though Nigeria failed to take the initiative of the Safe Motherhood, the initiative itself could not achieve its aim across the globe many years after it was inaugurated. Maine and Rosenfield (1999) argued that, the Safe Motherhood Initiative's lack of progress or failure was as a result of lack of focus. Global health expert, Fathalla, (1998) stated that the Safe Motherhood Initiative failed as a result of its cost-effectiveness and lack of resources in some states. Maine and Rosenfield (1999) furthered that its failure to also examine how it affected developing countries which were in debt crises as a result of the economic policies introduced by the world powers was also part of its weaknesses. This underscores the need for countries to invest heavily in healthcare especially in the health of women who are not just the saviours of their societies, gatekeeper of the homes but also of the future through child birth. It also stresses the need for global agencies to ensure that policies are made under enabling environment for developing countries.

Conclusion

The WHO's Safe Motherhood Initiative marked a pivotal moment in global efforts to reduce maternal mortality and ensure safer childbirth

practices, particularly in countries like Nigeria where maternal health was in crisis. While Nigeria's participation response to the initiative in 1987-1988 showed a commitment to aligning with international health goals, its failure to implement it as and when due showed that the nation was unprepared and lack of focus. This had implication for the country's women and nursing mothers and maternal health generally. Nigeria faced significant obstacles, including inadequate healthcare infrastructure, socio-cultural barriers, and a lack of sustained governmental support. Despite these challenges, the initiative sparked vital discourse on maternal health, leading to some improvements in healthcare policies and access to skilled birth attendants.

However, the long-term effectiveness of Nigeria's actions during this period remained limited due to inconsistent implementation and the persistence of systemic healthcare deficiencies. This case study underscores the need for a more integrated and locally tailored approach to maternal health, combining global frameworks with the realities of Nigeria's healthcare landscape. The Safe Motherhood Initiative laid important groundwork, but the journey toward truly ensuring painless childbirth in Nigeria continues.

---

[1] Excerpt of oral interviews held with Mojisola Adeyi, c. 59years., Kola, Lagos7 May, 2019; Maria H.O. Olayinka, c. 75years, Female, Abeokuta, 7 May, 2019.

[2] Excerpt from oral interview held with Akanni Kolawole, Male, around 71 years, 30-8-2019; Janet Musuru. Feale, Kajola village, Abeokuta, 85years, 25-5-2019

References

Abouzer, C (2003) "Safe Motherhood: A brief History of the global movement 1947-2002." *British Medical Bulletin*, 67:13-25.

Bradley, D. (1978) "Forward" In Arnold Pacey ed. *Sanitation in Developing Countries.* New York: John Wiley & Sons

Burke-Gaffney, H. J. O'D. (1966, September 23) The History of Medicine in The African Countries. A paper read at the Symposium on The History of Medicine in the Commonwealth, organised by the Faculty of the History of Medicine and Pharmacy, and held at the Royal College of Physicians of London.

Chamberlain, G. (2006). "British maternal mortality in the 19th and early 20th centuries" *Journal of the Royal Society of Medicine*, 99, 11: 559-560.

Chukudebelu, W. O (1990, September 10-11) "Welcome Speech on the occasion of the Nigerian Safe Motherhood Conference in Abuja". In Safe Motherhood Initiative Nigeria 1990: Reducing Death and disabilities from Pregnancy and Childbirth Vol II. Report of the conference held in Abuja Nigeria 11-13 September 1990, 5.

Concord Newspaper, (1990, July 10). "Festering problem of death during childbirth--A seminar report" 5

Cornia, G. A., R. Jolly R. & Stewart, F. Eds (1987). *Adjustment with a human Face: Protecting the Vulnerable and Promoting Growth, vol. I.* New York: Clarendon Press Publication

Drife, J. (2002). "The start of life: a history of obstetrics" *Postgrad Med J*, 78: 311;

Dundes, L. (1987). "The Evolution of Maternal Birthing Position" *American Journal of Public Health*, 77, 5: 636.

Every Woman, (1990, August 23). "A call for safe motherhood"

Falola, T (1980) "Economic and Social Development in contemporary Africa," 111-126. In *African History and Culture,* Richard Olaniyan ed. (*Ibadan*: Longman, 1980).

Family Care International, (2007) *Safe Motherhood: A Review: The Safe Motherhood Initiative 1987-2015.* New York: Family Care.

Fathalla, M. F. (1988, April 7), "Highlight and Challenges of Safe Motherhood" A Paper presented at the Safe Motherhood: Progress and Challenges Symposium on World Health Day Washington DC: World Bank

Fatuase, S. (1990, July 21). "FG supports reducing mortality rate" *The Punch*. p.14

Heidhues, F. & Obare, G. (2011) "Lessons from Structural Adjustment Programmes and their effects in Africa," *Quarterly Journal of International Agriculture*, 50, 1: 60.

Hope, J (2010) "What are the main functions of the World Health Organization?" E-IR Students, 8 November 2010. At https://www.e-ir.info/2010/11/08/what-are-the-main-functions-of-the-world-health-organization/ [Accessed 6 December 2018]

Hunger Notes, (1987, April-May) "Safe Motherhood" A newsletter of World Hunger Education Services, Vol. XII, Nos 11-12. 1987, np.

Loudon, I (2000). "Maternal mortality in the past and its relevance to developing countries today" *Am J Clin Nutr,* 72: 241S-246S.

Lucas, A. O. (1990). "Maternal Mortality and the Health System" In *Safe Motherhood Initiative Nigeria 1990: Reducing Death and disabilities from Pregnancy and Childbirth Vol II.* Report of the conference held in Abuja Nigeria 11-13 September 1990, 30

Maine D. & Rosenfield,A (1999) "The Safe Motherhood Initiative: Why Has it Stalled?" American Journal of Public Health, 89, 4: 480-482

Nneamaka M. Mojekwu-Chikezie, N. M (2012) *African Women: Sentenced by Tradition*. Lagos: Nwokebi & Co

Rosenfield A. & Deborah Maine, D. (1985). "Maternal Mortality --A neglected tragedy: Where is the M in MCH?" *The Lancet,* 83

Roth, D. M & Mbizvo M. T. (2001) "Promoting safe Motherhood in the community: The case for strategies that involve men" *African Journal of Productive Health*, 5(2):10-21

Starrs, A (1987) "Preventing the Tragedy of maternal Deaths: A Report on the International Safe Motherhood Conference," Nairobi Kenya February.

The Guardian, (1987, February 11). "How to curb maternal mortality" p, 5.

Thompson, O. O. (2021). A History of Maternal Healthcare Services in Abeokuta, 1895- 1987" Unpublished PhD Thesis, University of Ilorin, Ilorin, Kwara State, Nigeria

UNICEF, (1987). *UNICEF Annual Report 1987*, New York: UNICEF.

WHO (1987) Fortieth World Health Assembly, Geneva 4-15 May, 1987 Resolution and Decision Annex (Geneva).