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Social Contract: The Case of Maternal Health in Nigeria 1999 – 2008

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Abstract

The state of maternal and child health is both an indicator of a society's level of development and the performance of the health care delivery system. Many complications and subsequent poor outcomes for women are lessened by providing good quality care, including early detection of problems and appropriate and timely interventions. The paper used three rounds of the Nigeria Demographic and Health Survey data in comparing women's access and utilization of antenatal, delivery and postnatal care. The trend was examined in the light of the urgency of attaining the MDGs. The results show a worsening situation for safe motherhood. The social contract need be strengthened by the state intensifying its policies and programmes towards ensuring that the health and welfare of all persons are safeguarded and not endangered or abused; there are adequate medical and health facilities for all persons.

Keywords: Social Contract, Maternal Health, Antenatal, Contraceptives, Postnatal

1. Introduction

The concept of maternal health care encompasses preconception, prenatal and postnatal care. Prenatal care is the comprehensive care that women receive and provide for themselves throughout their pregnancy. Women who begin prenatal care early in their pregnancies have better birth outcomes than women who receive little or no care during their pregnancies. Postnatal care issues include recovery from childbirth, concerns about new-born care, nutrition, breastfeeding, and family planning. Maternal mortality remains unacceptably high across much of the developing world. Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age. The focus of the fifth Millennium Development Goal is improvement in maternal health. Fully achieving the Goal 5 target of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio remains a challenging task; it is the area of least progress among all the MDGs. More than 80 per cent of maternal deaths worldwide are due to five direct causes: haemorrhage, sepsis, unsafe abortion, obstructed labour and hypertensive disease of pregnancy (United Nations, 2008).

A key factor in this collective likely failure in achieving MDG 5 has been insufficient political will to drive actions to improve the health of women, both at the international and national levels. Becoming pregnant for some women in the world today is a cause not for joy but for fear, not a celebration of new life but an acceptance that death in childbirth is a very real possibility. Every year more than half a million women die due to complications of pregnancy and childbirth – 99 per cent in developing countries. A further nine million more women suffer complications that can result in life long pain, disability and socio-economic exclusion (DFID, 2007). Sub-Saharan women have a 1 in 22 lifetime risk of maternal death, compared to a risk of 1 in 7,300 for women in developed regions (UNICEF et al, 2007).

Social contract makes possible a form of association that will defend and protect with the whole common force, the person and goods of each associate, and in which each, while uniting himself with all, may still obey himself alone, and remain as free as before. There is equality of all citizens by virtue of social contract. In modern societies, there are rulers and the people, it is inferred that a social contract exists between them. More so, in this era of democracy where political parties provide platforms for individuals to seek positions of authority. The parties have manifestoes with which they canvass for votes. These manifestoes are forms of social contract between the people and the rulers. In political thoughts the social contract is the primary source of obligation for the people to demand service or the rulers to serve the people. Social contract is a label for philosophical explanations of what individuals and governments owe to each other (Bennett, n.d.). In this service the rulers

must seek the good and the general well-being of the ordinary citizens. The provision of adequate maternal health services is an indication of not breaching the social contract.

Historically, the social contract theories provided a modern foundation for morality and government. Hobbes begins with imagining what it would be to live in a "state of nature", that is, without rules or government. The state of nature is a state of war. *In a state of nature, we would be constantly on our guards, ready to fight. The deduced reasons for the state of war are related to four basic facts about humanity; these are: (a).* Equality of need – we all need the same basic things, (b). Scarcity of resources – there is not enough of these basic things, (c). Equality of power – whatever minor inequalities, the stronger is never strong enough to be beyond fear of others, and (d). Self-interest – at the end of the day, nobody is willing to sacrifice himself for nothing. The social contract, as understood by Hobbes, comes as a way out of the state of war.

Hobbes gives a version of social contract theory in which rights emerge at two levels. First, people have some rights even in the state of nature. These are natural rights that do not depend on government. Second, people have rights bestowed by governments, which they acquire through the social contract. These are social or civil rights, such as that entrenched in the Nigerian constitution - Article 17 Section 3(c and d); which stipulates that "The State shall direct its policy towards ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; there are adequate medical and health facilities for all persons." This provision of the Nigerian constitution suggests that a social contract exists between the government and the people. Attention is focussed on mothers in this paper, even though the social contract is with all the citizenry.

In any version of social contract theory, two questions could be asked that determines much about the theory of government that results: first, what do the parties hope to gain by entering into the social contract? Secondly, what are they willing to give up achieving it? (Bonevac, 1996). In Hobbes's theory, the parties hope to gain security, which for them is a matter of life and death. In the views of John Locke, people would give up their right to enforce the laws of nature by themselves. But they would retain their natural rights to life, liberty, and property, as long as they did not violate the rights of others. Jean-Jacques Rousseau provides a third version of contract theory, in which people are willing to give up everything in order to regain everything. To Rousseau the state of nature is inconveniencing and difficult. For Rousseau, there are no natural rights; all rights arise from the social contract. All rights are for him – civil rights. Government, according to Rousseau, has only one constraint: that it acts in accord with the general will, that is, for the best of the whole community.

There have been arguments that the fact that there is no way to determine when one enters into the social contract and more importantly is the issue of how the social contract was arrived at, makes it difficult to ascertain when an individual gets in to the contract. Moreover there is never a meeting of all members of the community in which decisions are made on the contract. This riddle is answered to by the mere fact of citizenship of a country. As the case is in Nigeria, in which the preamble of the constitution states that:

> "We the people of the Federal Republic of Nigeria, having firmly and solemnly resolved, to live in unity and harmony as one indivisible and indissoluble sovereign nation under God, dedicated to the promotion of inter-African solidarity, world peace, international co-operation and understanding and to provide for a Constitution for the purpose of promoting the good government and welfare of all persons in our country, on the principles of freedom, equality and justice, and for the purpose of consolidating the unity of our people, do hereby make, enact and give to ourselves the following Constitution:*". (FGN, 1999)*

The individual is bound by the jurisdictions of the laws and statutes of the land to which the person holds citizenry. With the social contract, a similar situation occurs. That is, when one is born, they are--by default--entered into the social contract by the sole fact that they are a human and born into a society. This constitutes their implicit consent and they may choose to, when they are rationally fit to do so, waive those rights granted under the Contract and leave the social order. Such is the maintenance of the contract upheld. Social contact can either be implicit, explicit or hypothetical in nature.

The fact remains that the social fabric continues to be maintained through the roles of women in the process of child-bearing. Thus the onus is on the society in general and the government in particular to ensure that the right and favourable environment is created for those fulfilling this role.

In order to maintain social order and reduce the inequalities brought about by capitalism, it was necessary to offer assistance to those members of the society who found themselves on the periphery of the market economy (Giddens, 2005). The implication of this is the need for a system to be in place to cater for the needs of the weak

members of the society, and the health of mothers and children are important as these are the weakest constituents of any community. Social contract goods are individual goods that the collective society has decided every citizen needs to have and the goods need not be provided only by government, private sector can also provide the goods (Lind, 2007). Health care services is an example of this good and both public and private sector are involved in the provision. The social contract should ensure that all women irrespective of their socio-economic status are provided with maternal healthcare services necessary for safe motherhood.

2 Materials and Methods

The data for this paper was drawn from the Nigeria Demographic and Health Survey (NDHS) for 1999, 2003 and 2008. The NDHS over the years has been a nationally representative sample covering the entire country. The sample is drawn from women age 15-49 in selected households. Even though men were also interviewed, but only the women data was used in this paper. The survey is designed to measure levels, patterns and trends of demographic and health indicators. Only the data of women age 15-49 who have had a live birth in the last five years preceding the surveys, and only data for the woman's most recent birth on issues of antenatal care, delivery and postnatal care were used in other to understand the links between poverty and maternal health. Percentages were employed in understanding the trend.

Table 1: Background characteristics of women age 15-49yrs who had a live birth in the past five years preceding the survey.

	NDHS 1999	NDHS 2003	NDHS 2008
Place of Residence			
Urban	29.6	35.8	26.9
Rural	70.4	64.2	73.1
Age			
15-19	8.1	8.2	6.7
20-24	20.4	20.6	19.2
25-29	26.8	27.4	26.2
30-34	20.6	19.0	19.8
35-39	15.2	13.9	15.2
40-44	6.1	7.9	8.6
45-49	2.7	2.8	4.3
Educational Attainment			
No education	50.1	49.0	49.0
Incomplete primary	6.6	9.1	6.9
Complete primary	17.2	15.3	15.7
Incomplete secondary	16.0	13.8	11.0
Complete secondary	5.7	8.8	12.2
Higher	4.3	3.9	5.3
Marital Status			
Never married	1.7	2.7	2.6
Currently married	95.5	93.1	94.2
Formerly married	2.8	4.1	3.2
Total (N)	100.0 (4,007)	100.0 (3,775)	100.0 (18,576)

Source: NDHS, 1999, 2003 and 2008

3 Results

Majority of the women between 15-49years who had a live birth in the last five years preceding the surveys live in the rural areas (Table 1). Majority of the women are between 20-34 years age bracket. About half of them have no formal education, while marriage is virtually universal among them.

Table 2: Percentage distribution of Respondents with Access to Safe Drinking Water and Sanitation.

	NDHS 1999	NDHS 2003	NDHS 2008
Household source of water			
Piped Tap	24.3	15.7	8.7
Open well	37.1	33.0	22.6
Protected well	24.3	19.7	37.0
Spring/River/Stream/pond	0.3	21.8	24.9
Rainwater	0.9	0.9	2.0
Tanker truck/vendor	1.7	6.4	1.8
Bottled water	9.6	0.5	1.1
Other	0.4	0.1	1.0
Not dejure resident	-	1.7	0.8
Missing	1.4	0.1	-
Type of toilet facility			
Flush toilet	10.1	10.0	10.9
Traditional Pit latrine	55.4	58.6	25.3
Ventilated Improved Pit(VIP) latrine	7.0	2.1	26.4
Bush/Field/River	25.7	27.5	33.9
Other	0.2	0.0	2.4
Not dejure resident	-	1.7	0.8
Missing	1.7	0.0	0.4
Total (N)	100.0 (4007)	100.0 (3775)	100.0 (18,576)

Source: NDHS, 1999 and 2003

Source of water available to the household a woman is, as well as the sanitation facilities could have effect on the health of the woman in particular and the health of every member of the household in general. Panel 1 of Table 2 shows the distribution of household source of water. At least half of the women reported that their households depended on well for their source of water. In the earlier rounds of the NDHS most of the household that depended on well as source of water for their households had open well. This changed in the 2008 round of the survey, more households had protected well as their source of water. Table 2 showed that there is a reduction in the proportion of women with access to piped taps in their household, while a there is an increase in the proportion of households that relied upon rivers/streams/ponds/springs in 2003 and 2008 relative to the proportion in 1999. In terms of sanitation, at least 55 per cent of the households in which the women belong to depended on the use of traditional pit latrines in 1999 and 2003 (Table 2). The proportion of households using traditional pit latrine reduced drastically in 2008 relative to the situation in the earlier surveys. There is no change on the proportion with access to flush toilet (only 10 per cent). This may partly be due to the non-availability of piped tap water necessary for flush toilet in the rural areas where a great majority of these women reside.

Table 3: Percentage Distribution of Respondents by their Knowledge, Attitude and Use of Contraceptives

	NDHS 1999	NDHS 2003	NDHS 2008
Proportion who know any method	66.2	80.1	67.0
Proportion who ever used any method	28.2	32.9	26.6
Proportion currently using any method	15.0	14.9	13.4
Proportion who discussed family planning with partner	38.1	37.4	n.d.
Proportion who approves of family planning	75.1	58.7	n.d
Number of women	4,007	3,775	18,576

Source: NDHS 1999, 2003 and 2008

The fact that a woman is within the reproductive age and married predisposes the woman to becoming pregnant. There are options available to every woman to either want to limit or space the number of children to have and when to have another child. Abstinence may not be a practical option compared to contraception. The issue of contraception has implication for the occurrence of another pregnancy; as such it is germane to examine issues related to contraception. The proportion of women with live birth in the last five years preceding the surveys who have knowledge of any method of contraception increased in 2003 relative to 1999 but the proportion reduced in 2008. This may be an indication of the consequences of reduction in the enlightenment programmes and activities on family planning by various stakeholders or that enlightenment programmes have been more directed at the urban areas. There is a decline in the proportion of women who gave birth in the last five years before the survey and have ever used any contraceptive in 2008. Though there was a positive change in the proportion who have ever used contraception in 2003 relative to those in 1990. The proportion currently using any method of contraception has been on the decline over the years under consideration (Table 3).

Access to safe and effective contraceptive services will go a long way in enhancing the chances that a woman would have a pregnancy when she or her family so desires. The availability and use of contraceptives will considerably reduce lifetime risk of death a woman is likely to face due to pregnancy and childbirth related issues. The maternal mortality ratio is a measure of the risk of death a woman faces every time she becomes pregnant. Thus, in countries where fertility is high, women face this risk many times. Nevertheless, once a woman is pregnant, skilled medical care is essential to ensure her safety and that of her baby.

Routine visits to health facilities with physical examinations and routine laboratory tests are part of prenatal/antenatal care a pregnant woman is expected to have in the course of her pregnancy. It is normal that in obstetric practice, an obstetrician or midwife will see a pregnant woman on a regular basis to check the progress of the pregnancy. An individual woman's schedule of antenatal appointment varies depending on local resources and the pre-disposing risk factors she may be faced with. The main rationale for these visits is to ensure that pregnant women do not suffer untold hardship in the course of fulfilling their biologically imposed role of child bearing, by detecting early diseases that could endanger their lives.

Antenatal care is a core component of maternal health services. It is important for diagnosing and treating complications that could threaten the lives of mother and child. The reality is that care during pregnancy is an important opening to deliver interventions that will improve maternal health and survival during the period immediately prior and after birth.

Table 4: Percentage Distribution of Respondents by Antenatal Care Provider, Number of Visits and Timing of First Visit

	NDHS 1999	NDHS 2003	NDHS 2008
Antenatal Care provider			
Doctor	19.0	21.7	19.6
Nurse/Midwife	41.2	51.1	37.2
Auxiliary midwife	2.0	2.0	6.9
Community health extension worker	-	2.0	-
Traditional Birth Attendant	3.9	3.4	3.5
Other	0.7	0.6	0.4
No one	23.7	33.5	37.8
Number of antenatal care visits			
None	23.7	33.5	37.8
1	1.4	2.6	1.6
2-3	7.0	11.5	9.0
4+	36.8	49.7	41.4
Dk	6.6	2.6	6.6
Missing	24.4		3.7
Number of months pregnant at 1st ANC visit			
No antenatal care	23.7	33.5	41.3
< 4	12.1	17.3	15.4
4-5	25.2	28.0	26.4
6-7	12.1	18.3	14.2
8+	1.5	2.0	1.6
Don't know/missing	25.3	1.0	1.0
Median months pregnant at first visit (for those with ANC)	*5.0*	*5.0*	*5.0*
Total (N)	100.0 (4,007)	100.0 (3,775)	100.0 (18,576)

Source: NDHS, 1999, 2003 and 2008

The situation of antenatal care by the sort of provider, number of antenatal care visits as well as the timing of the first visits are indicated in Table 4. Quick examinations of the results in Table 4 showed that 60.2 per cent, 72.8 per cent and 56.8 per cent of the women who had at least a child in the last five years preceding the survey had their last birth attended to by skilled health personnel (Doctor, Nurse or Nurse/Midwife) in 1990, 2003 and 2008 respectively. The worrisome thing is that the proportion of women 15-49years who had a live birth in the last five years preceding the survey but never received antenatal care has been on the increase over the years.

Attendance of antenatal care is good and being attended to by health professional is very vital, but more important is the sort of care given in the course of the visit. There was an increase in the proportion of women who made at least 4 antenatal care visits in 2003 relative to 1999. This trend did not continue in 2008 but it rather reduced to 41.4 per cent. Less than 20 per cent of women who had live birth in the last five years made their first antenatal care visit before the fourth month of their pregnancy. This is buttressed by the median months pregnant at first visit, which is five months (Table 4). Ideally, the first antenatal care visit should be as soon as the woman realises she is pregnant.

Table 5: Percentage Distribution of Respondents who received Antenatal Care for the most recent birth who received medications and dosage of Tetanus Toxoid Injections

	NDHS 1999	NDHS 2003	NDHS 2008
Medications taken			
Received/bought iron tablets/syrup	n.d.	84.4	50.0
Took anti-malarial drugs	n.d.	48.0	21.6
Dosage of tetanus toxoid injections			
None	40.5	18.9	45.7
One injection	11.9	16.5	9.2
Two or more injections	45.3	61.7	40.9
Don't know/missing	2.3	2.9	4.1
Total (N)	100.0(3034)	100.0 (2511)	100.0 (18,576)

Source: NDHS, 1999, 2003 and 2008
n.d. = No Data

Elements of the routine care given in the course of antenatal visits include treatment of infections, intermittent preventive treatment for malaria among others. Table 5 shows the sort of services received in the course of attending antenatal care. The data on medications were not available in the 1999 NDHS, but the figures in the 2003 NDHS, indicated that less than half of the women who received antenatal care took anti-malarial medications, a much lower proportion took anti-malarial medications in 2008. This calls for worry as Nigeria is a malaria endemic country and majority of these women are in the rural areas. A similar pattern holds for the use of iron tablets/syrup (Table 5).

The proportion of women who never received tetanus toxoid injections while pregnant is highest in 2008 than the proportion who never received the injections in 1999 and 2003 (Table 5). This is an indication that pregnant women are not receiving optimal antenatal care, especially when majority of the respondents are in the rural area where they are more susceptible to wounds and injuries that may become infected.

Table 6: Percentage Distribution of Respondents according to Delivery and Postnatal Care

	NDHS 1999	NDHS 2003	NDHS 2008
Place of delivery			
Public sector facility	17.8	20.9	19.8
Private sector facility	10.1	18.1	11.8
Home	46.8	62.2	63.5
Other	1.2	0.5	1.5
Missing	24.0	0.3	3.5
Person who assisted during delivery[1]			
Doctor	5.8	7.8	8.0
Nurse/midwife	27.8	30.7	26.9
Auxiliary midwife	2.3	1.4	5.7
Community health extension worker	-	1.0	-
Traditional birth attendant	16.4	17.1	22.1
Relative/Other	20.6	26.4	22.2
No one	9.4	15.2	18.0
Don't know/Missing		0.4	
Proportion checked by health professional after birth	31.7	29.5	26.6
Health professional that checked[2]			
Doctor	5.8	10.0	46.4
Nurse/midwife	24.4	23.9	44.2
Auxiliary midwife	1.5	2.5	7.0
Community health extension worker	-	8.2	1.3
Traditional birth attendant	16.3	52.0	0.2
Other	19.0	2.3	0.2
Missing	23.5	1.1	0.7
No one assisted	9.4	-	-
Total (N)	100.0(3034)	100.0 (2511)	100.0 (18,576)

Source: NDHS, 1999, 2003 and 2008

Deaths arising from the complications of pregnancy will be greatly reduced as more women deliver their babies in health facilities. This is because management of any complications will be easier at a health facility and should there be need for referral to the next level of care, such will be done promptly. The place of delivery is another central issue after having attended antenatal care. The data show that about 27.9 per cent of the women who had live birth in the last five years before the 1999 survey delivered in a health facility; 39 per cent and 31.6 per cent of the same category of women delivered in health facility in 2003 and 2008 respectively (Table 6). Among women who delivered in a health facility, public sector facility is the place of choice for more than half of them over the years. The proportion of women who delivered at home continues to be on the increase over the years under review.

Less than 40 per cent of the women who had a live birth in the last five years preceding the surveys in 1999, 2003 and 2008 were assisted by a skilled person during delivery (Table 6). The increase in the proportion of women assisted by a skilled person during delivery as shown by the survey in 2003 relative to 1999 was not

[1] Most skilled person of those who assisted
[2] This is only for those who had post-natal check up

sustained in 2008, the proportion reduced. The proportion of women who were assisted by TBA or other relatives increased, as well as those never assisted.

The proportion checked by health professional after birth continues to decline. Examination of the type of health professional that checked the women showed a continuous increase in the proportion of women checked by skilled health professional after birth.

4. Discussion

In Nigeria, there are more health facilities in the urban areas than the rural areas. This is partly due to the fact that most of the private sector facilities are situated in the urban areas. This has implications for the health of people in the rural areas, especially pregnant women. As the data has shown at least 64 percent of women with a birth in the last five years before the three rounds of NDHS in Nigeria reside in the rural areas. The responsibility of government at all levels is to ensure the availability of healthcare facilities to all Nigerians irrespective of their place of residence. Right to health and life are part of the social contract in the Nigeria project.

The increase in the proportion of women who disapprove use of family planning coupled with the high proportion who have never discussed family planning with their husband is an indication of the need for more enlightenment on the importance of the use of contraception to safe motherhood in particular and population control of the country in general. This is because the non-use of contraception is likely to increase the chances of a woman having an unplanned pregnancy. The consequences of this low rate of use of family planning methods include a high occurrence of unplanned and unwanted pregnancies (CRR and WARDC, 2008). The fact that the proportion of women who have ever used contraception is reducing over the years is partly due to the fact that less and less women are adopting the use of contraception. It is also a reflection of the fact that less attention is being given to enlightenment programmes that encourages women of childbearing age to use contraception either to space or limit the number of children she will have in her life time.

Clearly, a woman's ability to plan how many children she wants and when she wants them is central to the quality of her life. The ability to control fertility can be given through family planning programs. If this issue is not quickly addressed the population of Nigeria will grow faster and the attending consequences on the provision of necessary social infrastructures will be more burdensome to government. Such a situation could also lead to a further worsening of Nigeria's health indicators. At least a quarter of annual maternal deaths could be averted if unplanned pregnancies are prevented (DFID, 2007). Short child spacing can have negative effects on maternal health (Grant, 2005). In addition to reducing fertility (births per woman), family planning use has a direct, positive impact on reducing maternal deaths.

Risks of pregnancy-related complications are greatly reduced when pregnant women register early for antenatal care at the nearest health facility to them. The old belief that you seek healthcare services only when you are sick has to change, especially as it affects pregnant women. In Africa, it is often seen as being strong when a pregnant woman does not visit a medical facility till time of delivery. It is beliefs like this that has made Nigeria one of the worst countries to be a mother. Indeed, Nigeria remains 1 of the 10 most dangerous countries in the world for women to give birth (Cooke and Tahir, 2013). There is the need to enlighten pregnant women to register early for antenatal care, and to keep their antenatal appointments for this will reduce risk of having complications which are avoidable. The aim of giving iron and folate supplements and malaria prophylaxis routinely at antenatal visits in developing countries is partly to prevent severe anaemia. Furthermore, malaria prophylaxis is meant to mitigate the complications of malaria in pregnant women thus improving maternal health and foetal outcomes (Osungbade et al, 2008). The proportion of women who received/bought iron tablets/syrup or took antimalarial tables during the pregnancy of their most recent birth calls for urgent action.

The surge in the proportion of women who deliver their children at home is rather worrisome, for this limit the chances of receiving quality care should there be any onset of complications. Millions of women are left without care at the birth of their babies - nearly one in four women in developing countries is alone, or with only a relative or neighbour to assist them at childbirth – this has not changed since the early 1990s (DFID, 2007). According to DFID (2007), almost all maternal deaths could be averted with access to professional care during pregnancy and childbirth and the few weeks after, as well as access to emergency obstetric care in the event of complications.

As Thoraya Obaid, a former Executive Director of the UN Population Fund (UNFPA) told us, part of empowering women is engendering the understanding that health is a human right. Taking a rights-based

approach to maternal health helps link the provision of services to national governments' legal obligations enshrined in human rights treaties and principles, and is therefore a means of enhancing political accountability. The implication of this is that maternal health is a component of the social contract governments at all levels have with the citizenry. Sexual and reproductive health and rights, defined in the International Conference on Population and Development's Programme of Action, are critical to meeting all the MDGs, particularly those on maternal and child health and HIV prevention (DFID, 2007). While the Nigerian government has repeatedly identified maternal mortality and morbidity as a pressing problem and developed laws and policies in response, these actions have not translated into a significant improvement in maternal health throughout the country. One key structural issue is the division of health-care responsibilities among the three tiers of government: federal, state, and local. The Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities. (CRR and WARDC, 2008)

The health and survival chances of a new-born baby are largely determined by the mother's health and nutrition and prenatal and antenatal care that she receives. To make the best possible progress in reducing maternal deaths and disability, there must be the political will to act. Improving the status and rights of women and increasing all women's access to essential maternal health services must be made a priority concern. (DFID, 2007). This is necessary if the worsening situation of maternal health care is to be stopped and reverted.

5. Conclusions

Social Contract Theories are theories of the foundation of morality and of the legitimacy of political authority: (a) According to social contract theories, morality consists in the set of rules that rational, self-interested people will accept as necessary conditions of social living and under the condition that others accept them as well (b). Implementing these rules involves giving up some of one's liberties to a common power – the government. One abandon just as much power to the others as one gets from the others. One never can abandon the right to protect one's life. Thus when there are not improvements in the lives of the people from their own perception, the people could become disillusioned with the system and there could be breakdown of social order. This could result from either the worsening of their health status or the non-provision of health services that makes living worthwhile. The truth is that the state's role remains legitimate only as long as citizens agree to let it continue. Social Contract Theories offer the reasons why we follow moral rules. Conversely, if the conditions justifying that we follow the rules are not satisfied, then there is no justification to follow the rules anymore. Social Contract Theories can be seen as giving some important foundation to modern democracy.

From the results above, it is clear that motherhood in Nigeria continues to be a 'curse' for women in Nigeria. This is because virtually due to the fact that the indicators are not improving but rather worsening. Providing sufficient financing to strengthen health systems, particularly for maternal, childcare and other reproductive health services, and ensuring that procurement and distribution of contraception, drugs and equipment are functioning are part of the means for government at all levels to fulfil their own part of the social contract. Sometimes these social contracts are stipulated by the international community (and becomes effective as a country ratifies the convention/signs the declaration or treat) as exemplified in the millennium development goal, to which reduction in maternal mortality is core. Therefore, governments need to establish dedicated national programmes to reduce maternal mortality and ensure universal access to reproductive health care, including family planning services especially at the rural areas.

The idea of the National Health Insurance to provide free maternal and healthcare services to pregnant mothers and children under five years is a good idea and the current pilot programmes in some states is commendable and efforts should be made at ensuring that this program covers every town and village in the country. This is more because of the adage that "health is wealth", and in a situation where women constitute about half of the population and women within the reproductive age are also active members of the labour force. As such the death of women within this age groups have definite implications for the country in virtually all ramifications. The need to intensify the training of skilled health personnel to attend to women during and after pregnancy and childbirth is a non-negotiable component of government's social contract. This is essential if the health indicators of Nigeria is to improve in the nearest future.

It is true that Social Contract theories needs some refinements, for as it were for now, there are no implicit contract signed between the governed and those saddled with the responsibilities of governance. The fact remains that our societies function under an implicit contract. In the words of White (2007), trends in many of the world's economic, environmental and social vital signs send an urgent message that wealth disparities, the

precipitous decline in the quality of ecosystems, and challenges to children's and women's health are not being corrected at the rate at which they must be to avoid a century of instability and strife among nations and cultures. So the issue is not just about the quest to meet the millennium development goals but to ensure that those who are saddled with the responsibility of keeping the society going do that with minimal stress.

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