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LIST OF ARTICLES

1. The Plights of the Aged Inmates in Nigerian Prison System: A Survey of Two Prisons in Ogun State, Nigeria- **Ojo, Mathias Olufemi Dada and Okunola, Rashidi Akanji.** 1-30
2. Globalization and Changing Cultural Values in Nigeria: Driving Westernization to its Zenith
-**Mohammed Usman.** 31-46
3. Marriage and Modernity: The Challenge of Legalizing Same Sex Marriage in Nigeria-
Abejirinde, Ayodele Adedeji and Oyintonyo, Michael Olomu. 47-56
4. Socio-Cultural Correlates of Food Intake Among Pregnant Women in Ijebu-East, South-Western, Nigeria-
Onabanjo, Oluwasegun D. and Nwokocha, Ezebunwa E. 57-74
5. Poverty and Criminal Activities in Mushin Local Government, Lagos State, Nigeria- **Adegoke, Adeniyi** 75-94
6. An Assessment of Post-Retirement Life and Challenges Facing Pension Scheme in Nigeria-**Asamu, Festus Femi and Adedoyin, Temitope Helen.** 95-110
7. Psycho-Social Implications of Divorce and Single- Parenthood on Some Nigerian Women
- **Akinlotan, Raymond Adeniyi; Kesinro, Olalekan Rasheed and Abisoye, O. Amos.** 111-134
8. Parental Opinion and Preference for Sexuality Education Topics: A Case Study of Lagos Mainland-
Oke, Olubukola A. 135-150
9. Problems and Prospects of the Opposition Parties in Nigeria's Political System- **Ogunwa, Samuel Adetola.** 151-178
10. Challenges and Coping Strategies of Commercial Motorcycle Riders (*okada*) in Ibadan, Southwest, Nigeria
- **Emeka, E. Okafor and Adedeji, C. Ibitoye.** 179-206

11. Sanctity of Sex in Christian Marriage: An Exegetical Study of Hebrews 13:4 and its Relevance to Nigeria-
Oyetade, Michael Oyebowale. 207-222
12. Education as a Process for Transmitting Cultural and Moral Values to Rebrand Nigeria
- **Amali, Ismaila Oteikwu** 223-234
13. Facilities Utilization for Antenatal and Child Delivery in Two Communities of Northern Borno, Borno State, Nigeria- **Gazali Waziri A., Bababe Fatima and Mukhtar Falmata.** 235-250
14. Films and Matrimonial Harmony: An Assessment of the Impact of African Magic Movies on Audience from North-Central Nigeria- **Abdulbaqi, Saudat Salah and Mahmud, Abdurraheem.** 251-264
15. History and International Relations: The Question of Additional Nomenclature- **Lemuel, Ekedegwa Odeh.** 265-276
16. Africa and the World Trade Organisation: An Analysis of Internal Constraints to Effective Participation-
Elueze Chidinma. 277-298

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Socio-cultural correlates of food intake among pregnant women in Ijebu-east, south western, nigeria.

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Abstract (UNSTRUCTURED ABSTRACT)

Maternal health and morbidity in Nigeria has generated series of concern among individuals, agencies and Government. The concern could be linked to the deplorable conditions pregnant women live, their poor dietary habits and low food intake before, during pregnancy and Lactation. Low intake of calories in pregnancy not only affects mothers' health but also the child's health

Data was collected through Structured Questionnaire, Focus Group Discussions (FGDs) Observations and In-dept Interviews. Manual content analysis of qualitative data was done. On the other hand, quantitative data were analyzed by descriptive and bi-variate techniques through the use of computer package for data analyzes (SPSS version 15.0)

The findings shows that: Pattern of social relationships existing between family members like Mother- in-laws, parents, siblings, affine, cognates, members of religious group and neighbours have significantly influence nutritional intakes of women during pregnancy and lactation.

That men's choice of foods have significantly influence their wives' choice of foods and eating patterns, before and during pregnancy.

Like other Ijebu communities, there are limited culturally forbidden foods associated with pregnancy in Ijebu East.

conclusion: The study offered an in-depth understanding into series of factors relating to maternal health and morbidity and food intake of pregnant women

Key words: Food intake, Pregnant Women, Birth Weight, Nigeria

DOI:

Introduction

In Nigeria, like other less developed countries, women remain the primary care givers for their children as well as their husbands. In doing this, they have a major role in deciding the food intakes for members of the family as well as themselves particularly during pregnancy and lactation which are the most nutritionally demanding periods of a women's life (Ene-Obong, Enugu and Uwaegbule 2001). The nutritional and health status of women have become a great concern in the contem-

porary world because of the multiple roles played by women. The situation is worse in communities where societal norms on sex discrimination have forcefully subjected women to satisfying the health and nutritional needs of their families even at their own expense (Ene-Obong et al, 2001, Odebiyi 1989 and Ducker 1992, www.benson.byu.edu/Publication/BI/Lessons/volume21/Nutritionalhabits.asp, www./20.org/docrep/Noo73e).

Inadequate nutritional intakes during pregnancy can lead to ill health not only for the mothers but also for their babies who risk being left permanently predisposed to hypertension, diabetes and heart disease. (www.benson.byu.edu/Publication/BI/Lessons/volume21/Nutritionalhabits.asp)

Pregnant women eating patterns can be said to be strongly influenced by both their physical and social and economic factors. With regard to the physical environment, pregnant women are more likely to eat foods that

Corresponding author:

are suitable and easily accessible (Mishra 2002). Additionally, characteristic of the social environment including various socio-economic and socio-cultural factors such as educational qualification of the women and that of the husband, time constraints and ethnicity influence the types of foods eaten by pregnant women. Equally important among factors influencing eating pattern is mealtime structure which includes social and physical characteristic of mealtimes including whether families eat together, Television viewing during meals and the source of foods e.g (restaurants or prepared by the pregnant women themselves).

Siege-Rix, Herrmann, Savitz and Thorp (2000) in their study of eating patterns during pregnancy among pregnant women in North Carolina, observed that Meal patterning during pregnancy may be important because pregnant women who sustain prolonged periods of time without food by skipping meals may be inducing a physiologic stress upon their pregnancy. An average-sized well nourished women requires 10460 kJld (2000 kcal/d) of food intakes during pregnancy (Ladipo 2000:2) .

Many women in developing countries reduce their food intake during pregnancy so as to have smaller infants, on the premise that smaller baby will carry a lower risk of delivery complications. On the contrary, infants who are small or disproportionate at birth have increased health risks later in life (Ladipo 2000). Food deficiencies during pregnancies can result from lack of adequate knowledge about prenatal nutrition, dietary taboos associated with pregnancy and this, in turn have greater consequence for both mothers and newborn infants' health. This could result to pregnancy – induced hypertension which is a common contributive factor towards maternal mortality and morbidity in developing countries of the world.

Beliefs about foods have relationships with the cultural practices of the people and these beliefs vary from one society to another. In most cultural settings in Africa, food intakes are determined among other factors by taste (like or dislike) price

(expensive or cheap) nutritious and healthful, prestigious, filling, seasonality. Upon all, of greater importance is the Socio-Economic Status (SES) of the household (Odebisi, 1989). Also food preference of head of the household that is the husband is crucial in selecting

foods for the family among the Yoruba people of South Western Nigeria. This view is supported by a Yoruba saying that “Obe ti bale ile kije, Iyawo Ile kogbodo se” (Any food dislike by the husband must not be cooked by the wife.)

This submission is likely to influence food selection of pregnant women in equal direction particularly in Ijebu East area of Ogun State where men determine the family income and subsequently health seeking behaviour of their wives and to some extent types of food in takes. The implication is that those forbidden foods by the family head could be nutritional to the woman even in pregnancy.

Generally, most foods considered highly nutritious during pregnancy are expensive except for eggs and vegetables which are produced locally. (www.unu.edu/unupres/food2/uinofe/htm). Eggs, fish, meat, milk and other foods rich in protein are often considered prestigious foods and prestigious foods are generally consumed when there are guests or relatives or during special festivals or holidays. Families generally buy and bring fruits, milk powder and these foods considered prestigious when visiting relatives or someone who is sick.

This study among other things will examine food intake among pregnant women and Social-economic, cultural and environmental factors affecting nutritional intakes of pregnant women as well as their knowledge about food intakes during pregnancies

Objectives of the Study: The general objective of the study is to examine series of factors determining food intakes of pregnant women in Ijebu East, South western, Nigeria. While the the specific objective will be: to identify socio-economic, cultural and environmental factors affecting food intake of pregnant women in Ijebu-East Area of Ogun State;

Theoretical framework

Several sociological theories and models are in existence to explain social realities particularly as it relates to health and nutritional intakes in any human societies. For this study, Health Belief Model propounded by Kurt Lewin and later developed by Rosenstock, Kegels and Hochbaum and Culture bound Theory of Thomas Lambo (1955) and Yap.P.M (1951) will be applied to the subject under study.

Health belief model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health related behaviours (www.etr.org/recapp/theories/hbm). This is done by focusing on the attitude and beliefs of individuals. The model is based on the argument that a person will take a health related action (e.g use condom, eat balanced diet, engage in physical exercises e.t.c) if that person:

1. feels that a negative health condition(e.g HIV, Low Birth Weight, child mortality e.t.c) can be avoided;
2. has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition, and;

3. believes that he/she can successfully take a recommended health action.

On a similar note but different argument, Lawal (2008) noted that Health Belief Model (HBM) suggests the likelihood of an individual adopting a health –promotion behaviour depends on the perceived threat of disease in question. The HBM was spelt out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. Also included is the concept of self – efficacy or one’s confidence in the ability to successfully perform an act which was recently included in the model by Rosenstock et al in 1988 (www.etr.org/recapp/theories/hbm).

The HBM construct is further expressed in the table 1

Table 1: Health Belief Model Construct

Concepts	Definition	Application
Perceived Susceptibility	One’s opinion of chances of getting a condition	Define population(s) at risk , risk level; personalize risk based on a person’s features or behaviour; heighten perceived susceptibility if too low.
Perceived Severity	One’s opinion of how serious a condition and its consequences are.	Specify consequences of the risk and the condition
Perceived Benefits	One’s belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take: how, where, when, clarify the positive effects to be expected
Perceived Barriers	One’s opinion of the tangible and psychological costs of the advised action.	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate “readiness”	Provide how to inform, promote awareness, reminders.
Self – Efficacy	Confidence in one’s ability to take action	Provide training, guidance in performing action.

Source: www.etr.org/recapp/theories/hbm/resourses.htm

All the perceptions are modified by an individual’s personal characteristics, social settings, changes and costs required by an action (Lawal 2008) .Equally important as modifying factor is the previous life experiences particularly as it relates to previous pregnancies and maternal outcomes.

In the application of Health Belief Model to this study, it can be deduced from this model that, pregnant women are more likely to improve on their dietary intakes

before and during pregnancy if they perceive the likelihood of being affected by insufficient diets needed in pregnancy. This however, can be influenced by their previous pregnancy experiences, that of other siblings or neighbours. Also, the individuals’ present health condition in pregnancy for example anemia, and other related health problems can also influence their susceptibility which in turn will affect their dietary intakes in pregnancy. Equally important aspect of health belief

model which can be adapted for explanation of dietary intakes in pregnancy is the individual perceived severity of improper intakes of required nutrients in pregnancy. For example, if a pregnant woman cannot establish any danger in her nutritional behaviour, she is more likely to continue in her usual eating habits, however, she can thereafter improve on her nutritional intakes if she perceives any severity related to improper dietary intakes in pregnancy. This view compliments Talcot Parsons' argument in his Social Action Theory that "actions can be explained in the context of the subjective meaning given to it by the actor and that actions are always directed at the attainment of goals with the choice of the most appropriate method by the actor"(Nwokocha,2004).

Also, individual's perceived benefits from medical counseling on nutritional intakes during pregnancy has ability to either encourage or discourage further intakes of required nutrients in pregnancy. For example, where more benefits are perceived from

medical counseling on dietary intakes during pregnancy; pregnant women are more likely to improve on their dietary intakes irrespective of their socio-economic status. This becomes possible due to pattern of social interaction and influences of kinsmen in African Society. In relation to this study, individuals' perceived barriers to advised actions which could appear in form of financial constraints, psychological and environmental conditions, could go a long way to determine food intake of pregnant women in pregnancy. Since these women have no reality of their own outside that of their community, their choice of foods in pregnancy are more likely to be affected by series of factors within the social system. Also, advice from mothers, mother-in-laws, husbands and peers, counseling towards healthy living in pregnancy from health workers as well as their past pregnancy symptoms could act as stimulus or pattern of stimuli towards their dietary intakes in pregnancy.

Health Belief Model (HBM) is also applicable to the study by its emphasis on self efficacy which is centred towards individual's confidence in one's ability to take appropriate action towards their nutritional intakes. This argument can be linked to the view of Talcott Parsons in his voluntary social action theory that people's actions are directed towards the achievement of end goals. The principle of self efficacy as outlined in the Health Belief Model, by implication has direct links even to the eating

habits of pregnant women and their choice of foods in pregnancy and lactation. In a critic of Health Belief Model (HBM), it can be deduced that human beings influence their environment and are in turn influenced by it; as such, other variables such as demographic characteristics, socio-economic status, religion and culture which are likely to influence health behaviour are not critically accounted for in the model. These lapses will therefore be explored through the Culture Bound Theory of Lambo and Yap. The application of this theory will vividly account for this missing links between culture and dietary intakes in pregnancy.

Culture bound theory

Thomas Lambo (1955) of Nigeria and P.M.Yap (1951) of Hong Kong pioneered work on the cultural dimension of health among people of non-industrial societies. According to the theorists, health, diseases and curative measures are to some extent shaped by prevailing culture of the people. Religion which is incorporated into culture also plays significant roles in health seeking behaviour of the people (Erinosho, 2006). Due to this clue, nutritional intakes in pregnancy can be said to be relative base on relativity of culture which Lambo and Yap found not to be uniform across all human societies. Culture to a reasonable extent determines the behaviour patterns in health (Erinosho, 2006) and to a larger extent determine nutritional intakes of pregnant women and consequently maternal and child health (Odebiyi, 1989). Since culture is super organic and individuals have no reality of their own outside their culture, culture to a reasonable extent determines the total ways of life such as choice of contraceptives, rituals, dietary intakes in pregnancy and lactation. Erinosho(1978) and Oke (1996) As observed in Nwokocha (2004;68) noted the significant influence of culture on healthy life style of an individual and thus pointed out that one's social and cultural environments are dictated by norms which in turn define actions in a given social context.

In relation to this study, patterns of eating, food prescriptions and prescriptions, sickness and healing process, sexual activities, procreation and death are all cultural issues which define individuals' patterns of interaction within the social system and in turn enhances man's adaptability and mastering of his environment (Owumi, 1996). Social and cultural factors, although implicit, serve as both "receptors" and "effectors"

of stimuli towards outcomes. Thus, the actions of individuals with regards to family planning, delivery, post-natal behaviours and by extension dietary intakes in pregnancy and lactation are all moderated by norms and values of a society (Nwokocha,2004). Though individuals have ability to reason out their own social reality particular on reproductive health, parity and choice of foods. However, they are constrained within the norms and values of the society. The major limitation of this

theory is its ability to account for dynamism in cultural and effect of cultural diffusion which could maintain a notable change in life style of an individual.

Conceptual framework

Here, efforts will be made to apply the two theories into the subject under study.

This will be done graphically while a common focus of the theories will be extracted.

Figure1

Figure1

MODIFYING FACTORS

- Educational Staus of Women
- Socio-Economic Status of the family
- Family Structure, Monogamous, Polygamous.
- Knowledge of maternal outcomes risk
- Age, Occupation e.t.c
- Culture and Environmental factors
- Religion
- Previous pregnancy experiences

Perceived Susceptibility

- Maternal outcome risks "Low" as pregnancy is seen as 'normal' in most African society combined with tendency to consider fate as unavoidable matter.

Perceived seriousness

- Whether potential maternal outcomes would have serious consequences e.g maternal or infant morbidity or mortality. "HIGH"

Perceived Threat

- Pregnancy Complications 'Moderate'

Perceived Benefits

- Safe delivery of a live baby
- Normal pregnancy
- Freedom from pregnancy complications
- Good maternal health
- Short stay in the hospital post-delivery

Perceived Constraints

- Cost of care
- Lack of time to eat well due to multiple responsibilities
- Number of Family members living with the pregnant women.

- Lack of helping hands on domestic works

Likelihood of taking recommended actions

- Improving the quality of nutritional intakes.
- Frequent eating during pregnancy and lactation.
- Visiting physicians incase of eating disorder in pregnancy

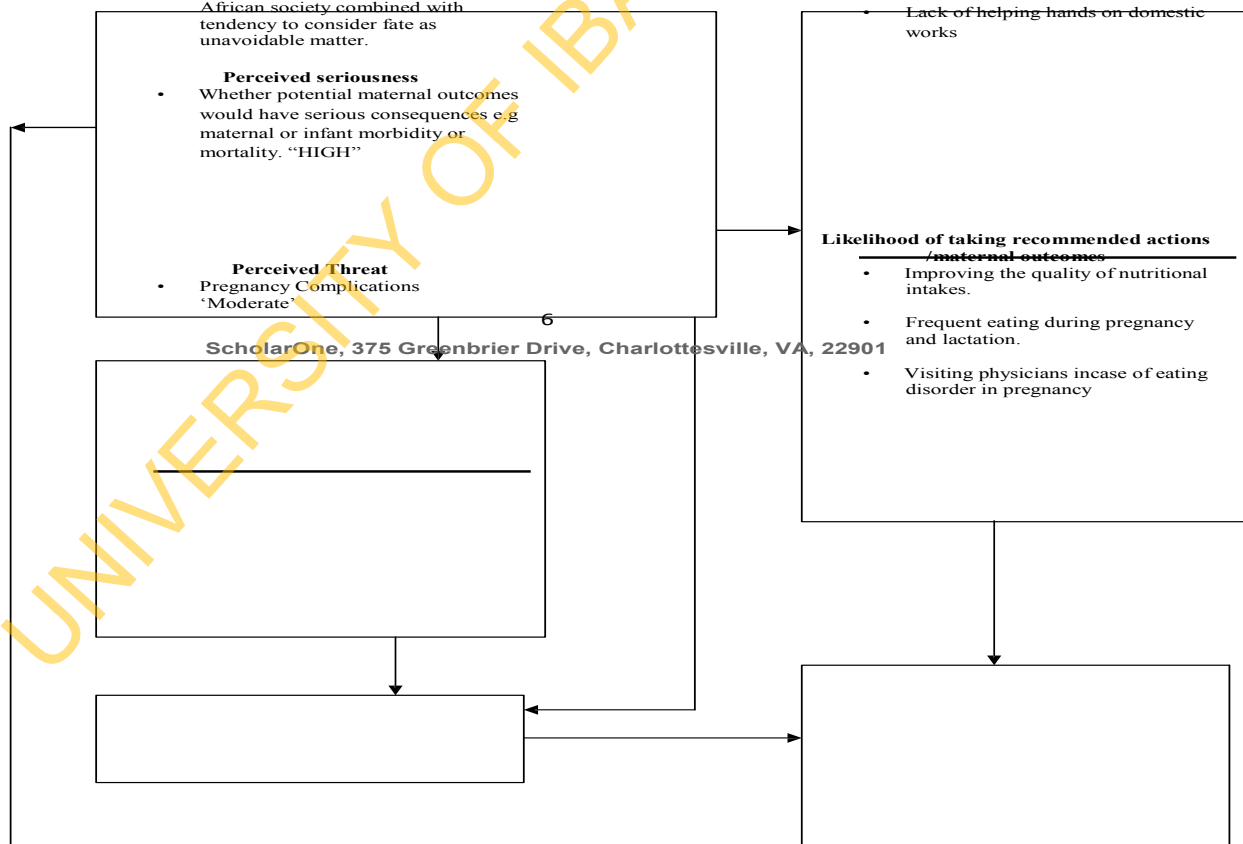


Figure 1 shows the interwoven relationships between various factors likely to influence eating pattern among pregnant women and their possible pregnancy outcomes in the study area. One basic assumption from above is that demographic variables and social relationships between mothers-in-law, Primary care givers (family members, religious groups, and spouse), past pregnancy experiences and secondary caregivers (Orthodox Medical Personnel, Traditional Medical Practitioners and Spiritualists) influence the knowledge, belief system, perceptions, and interpretation of health actions which in turn has capacity to influence their wellbeing either positively and negatively.

In African Society which is characterized with male domination, and the presence of culture, life styles, reproductive behaviour, family size, preference for a particular sex of children and dietary intakes before and during pregnancy are strongly influenced by these variables. It should also be noted that not until recent times where there are continual enlightenments towards improvements on women's education, there had been unequal access to western education among women and men in Nigeria with women at the disadvantage and this has affected their social economic status, life expectancy and by extension their dietary intakes either before pregnancy or during pregnancy (Anele, 2006). The disadvantageous position of women in Nigeria as noted in the works of Alliyu (2004) has not only affected their socio-economic conditions alone rather it has crept into their reproductive and family life. The social position of women therefore, has ability to influence their health seeking behaviour which has links with their dietary intakes and possibly pregnancy outcomes.

Equally important of all modifying variables on dietary intakes in pregnancy is the age of women. Among the Yoruba people of South Western Nigeria, the age of an individual plays vital roles on cultural issues. It dictates participation in rituals, religion and by extension decisions on marriage (Fadipe: 1991). To a larger extent, younger women are guided either by their mothers, mothers in-law, or husband during their early years of marriage particularly when such individual experiences pregnancy immediately after marriage. In most circumstances among the Yoruba people of South Western Nigeria, a wife is usually younger than the husband. She is regarded not only as a wife to the husband but also a sister who must be guided in all issues of life such as reproductive health, investments, socio-cultural activities

and dietary intakes in pregnancy. This singular cultural factor had made interventions possible particularly on dietary intakes in pregnancy which in turn has ability to influence the choice and use of health care facilities among women in Africa. This view aligns with the opinion of Oke (1996) as observed in Nwokocha (2004) that there is an inextricable association between socio-cultural factors and the use and non-use of health services.

In all issues, Yoruba people just like other tribes in Africa are religious. Religion had been described as a fundamental super-variable which influences an individual in all issues of life (Idowu; 1962). Since religion has ability to influence an individual's ways of life, including what to eat, where to eat, and when to eat. It then means that dietary intakes before and during pregnancy vis-à-vis other health seeking behaviour are likely to be influenced by religious practices of the people. Among the Yoruba people, a woman is not permitted to practise other religion different from that of the husband except where the man gives approval. Put differently, a woman has no religion of her own outside that of the husband. This factor, to a reasonable extent is an extension of patriarchy into religion which culture has permitted over the years and has indirectly subjected women to male domination. As a matter of fact, nutritional intakes of women, reproductive lifestyle, contraceptives and health seeking behaviour of Yoruba women had been affected inking their entrepreneurship capabilities (Alliyu:2004).

Profile of the Study Area

Research methodology

Ijebu – East Local Government can be regarded as one of the rural areas in Ogun State. The Local Government has Ogbere as its headquarters and four other major towns Ijebu-Ife, Itele, Imushin, and Ogbere with several rural areas Ajebandele, J4, Eregun e.t.c. Agriculture is the dominant occupation of the people in this local government with few government civil servants. The selection of this local government is done through balloting method from the list of available local government areas in Ogun State, Nigeria. The selection is limited to one local government area due to time and resources available to the researcher and the need to ensure validity and reliability of data.

There are two government owned hospitals in the area General Hospitals Ogbere and Ijebu-Ife. There are

twenty-two (22) registered Traditional Birth Attendants (TBAs), two (2) government owned hospitals and twenty-one (21) privately owned hospitals. Also, there are only two (2) medical doctors along with a Youth Corps medical doctor in the government owned hospital in the area. One of the doctors is in Ijebu-Ife and the other Youth Corps member is in Ogbere. There are fifteen (15) registered nurses and midwives (7 in Ogbere and 8 in Ijebu Ife) health attendants are 13 in number (4 in Ogbere and 9 in Ijebu-Ife) pharmacy technicians are four (2 in each location). The sources of water to the hospitals are deep well and commercial water vendors (Ogun State Health Bulletin, Vol. 1, 2004)

Study Design

The attitude, beliefs, perceptions as they relate to food intake during pregnancy and

maternal outcomes were investigated through Focus Group Discussions. Respondents were equally followed up to their respective homes and their eating patterns recorded. The correct interpretation of the in-depth interview and Focus Group Discussion (FGD) guide into Yoruba language were done. This was to ensure that the research instruments elicited information from the respondents with interviewer's biases avoided. The recorded nutritional intakes of pregnant women in the area were compared with the World Health Organisation (WHO) recommended nutritional intakes in pregnancy. The Focus Group Discussion (FGD) was used for dual purposes. (i) eliciting information on issues under study and (ii) familiarization of the researcher with the subjects, this in turn made the follow up exercise an easier one.

An assistant researcher who was trained was incorporated to assist in some documentation why tape recorder was used in the process.

Only women with six months old pregnancy (in their last trimester) were included in the study. The selection of these women was carried out on a visit to their Antenatal Clinic (ANC) day. All pregnant women with six months pregnancies in the study area who attend Antenatal (ANC) formed the subjects for the study. Apart from the two governments owned hospitals in the area, an extension of selection was made to privately owned hospitals operated by gynecologists in the area.

Focus Group Discussions

Respondents for each Focus Group Discussion were

homogeneous in character. Four

FGDs sections were carried out in the study area (One FGDs in Ijebu Ife, one in Ijebu Imushin and two in Ogbere). Each FGD population was made up of between 8 – 12 discussants. That was a function of available pregnant women. Each of the FGDs focused on different groups of discussants The Faith Healers, The Orthodox Health Providers, The Traditional Birth Attendants and the Pregnant Women. The selection of each group is to make room for divergent views on the topic of study.

In-depth Interview/Questionnaire

A total of six key informants were interviewed for the study. The selection of the informants was done through quota sampling technique. The key informants included the health care providers which are the Traditional Birth Attendants (TBAs) and Orthodox Medical Practitioners. The breakdown is as follows: two (2) Traditional Birth Attendants (TBAs), 2 Orthodox Health Care Providers (a doctor and a midwife) and two (2) Faith Healers (a Christian and a Muslim). These informants were selected to contribute to the knowing on Maternal Health Issues in the area particularly as it has to do with nutritional intakes of women in pregnancy.

The Traditional Birth Attendants were selected from the list of available TBAs in the area from the Association Chairman through whose help we were able to access the respondents. Since their leader had no prior knowledge of the study it would not have been possible for her to influence the responses of the respondents. The selection of orthodox health providers were done through simple random sampling. This method becomes relevant and convenient for use due to relatively fewer numbers of medical doctors and nurses available in the area. The Faith Healers on the other hand, the Christian informant was selected from list of religious houses who engage in child delivery process while that of the Muslim was done through accidental method of selection.

A structured questionnaire was used in the data collection exercise. The questionnaire had two sections, Section A which focuses on respondents' background and demographic features and Section B elicited information relating to nutritional intakes of women in pregnancy. Though the questionnaire was prepared in the English language, its administration was done in local language of the people which is Yoruba language. The purpose of this was to break the gap of language

barrier and to create room for adequate participation from the people. In addition to the questionnaire, discussion guide was also prepared for the Focus Group Discussions and In-depth Interviews. Responses during the interviews and discussions were recorded in tapes. This helped in recording verbatim the responses of the respondents.

Data analysis

Descriptive and bi-variate analyses were carried out on data collected for the

study. A pre coded sheet was prepared for data collected to clean data before and after analysis which was done through the Statistical Package for Social Sciences (SPSS

15.0) Also Information recorded through the tapes were carefully transcribed to prevent loss of information. This became necessary as English and local language of the people (Yoruba Language) were used in the study. A descriptive analysis of data was done using univariate frequency distributions and cross-tabulation

Data analysis

of variables whose combine influence could have affected nutritional intakes of pregnant women in the area. The socio demographic variables examined are age, religion, education, occupation, ethnic group, marital duration and children everhad. Interrelationships between demographic characteristic and their nutritional intakes were examined through bi-variate analysis and chi-square statistical tools. Significance relationships between the variable were tested at 0.05 level of significance.

Ethical Issues

International ethical standards were maintained in the study. This was done to ensure that rights and integrity of respondents and discussants were protected. Respondents and discussants were told the main purpose of the study and the likely benefits apart from the fact that it will enrich academic discourse and influence policy making and programme in the future apart from the award of a post graduate degree. That confidentiality will be maintained throughout the study.

Table 2. Socio-Demographic Characteristics of the respondents

Variables	Categories	Frequencies	Percentage %
Age	18-22	47	20.4
	23-27	70	30.4
	28-32	53	23.0
	32-36	35	15.2
	37-41	21	9.1
Religion	Christianity	118	81.3
	Islam	43	18.7
Education	Primary	306	227
	School Cert.	128	58.2
	NCE/OND	31	14.1
	Tracing	11	5.0
Occupation	Full	81	36.3
	Housewife	28	12.6
	s Civil	43	19.4
		53	23.0
Ethnic Group	Yoruba	17	7.7
	Isoko/Urobo	101	10.1
	Ig	20	8.7
		21	9.1
Marital Duration (In Years)	1-5	08	3.4
	6-10	102	52.0
	11-15	52	26.5
	16+	27	13.8
Children Ever had	1-3	15	7.7
	4-6	109	65.2
	Total	145*	100

Source: Data collected from field work by the author(December,2008) * Where total number did not add up to 230, subjects have denied some information

From Table 2, there are more younger women in the reproductive range (18-32 years of age), this accounted for 78.4% of the studied groups. However, as these women advanced in age, child bearing reduced. This could be linked to the effect of early childbearing in the area which is culturally valued as early childbearing is believed to have conferred social status on couples. For this purpose, early marriage is also encouraged so as to help women have their desired number of children and stop child bearing at younger age. This complements the findings of Isiugo-Abanihe (2003), that the Yoruba people of south western Nigeria ensures that their children are appropriately married at a very relatively mature and young age so as to legitimize sexual relationships and childbearing.

Also, the study revealed that there are more christians (81.3) in the study area than muslims (18.7). Variation in religion could be linked to early arrival of christianity to Yoruba land particularly Ogun state where the study was carried out. The early arrival of christianity closely married with western education could have made significant impacts at every points of these people's lives. Most of the subjects 58.2% had secondary education while 22.7% had primary education. Only 19.1% had higher educational qualification. Low level of education among these people can be linked to the rural nature of the community where people who are well read are likely to have migrated to urban centres or more developed neighbouring communities in search of better conditions of living. The few well read subjects in the study area are civil servants serving in schools, hospitals and local government offices.

Series of economic activities are engaged in by the subjects for the study. Majority engage in trading (36.5%), followed by 18.5% who are civil servants and 14.9% artisans. These higher numbers recorded in trading, civil service, artisanship could be linked to the pres-

ence of local government secretariat in the study area which has along with it schools and a divisional police headquarter. The study area is predominantly Yoruba community; this manifested with 78.7% Yoruba respondents in the study. Others from different ethnic groups are migrant workers, traders and those married to Yoruba men in the community.

There are more respondents whose marital duration ranges between 1-5 years old. This could be that marriage among women is generally early and universal, moreso, it confers status and security on them. It is within marital union that child bearing is legitimize (Isiugo-Abanihe, 2003:2). Marriage is important to women in any society and sometimes men. For this singular fact, individuals who decide not to be married except for religious reason (celibacy) are considered immature, sick or irresponsible. In another argument, higher rate of child bearing is likely to take place within the first five years of marriage except where procreation is prevented either voluntarily through the use of contraceptives and absence of a partner or involuntarily through sterility or death of a partner. This factor manifested the number of children available to the respondents with majority 55.2% having between 1-2 children. Fertility witnessed a sharp reduction from 20% among those who already have three children to 11% of those with four children and above.

Cross-Tabulation and Chi-Square Analysis:

Cross-tabulation of variables such as age, religion, education, occupation, ethnic group, marital duration and number of children ever had are presented to understand existing relationships between food intake of pregnant women and their socio demographic characteristics. Chi-square significant values of relationships between these variables are established.

Table 3 examined relationships between respondents' age and their nutritional intakes in pregnancy. Age of the respondents is found to have significantly influenced their nutritional intakes in pregnancy with the chi-square value of 0.001.

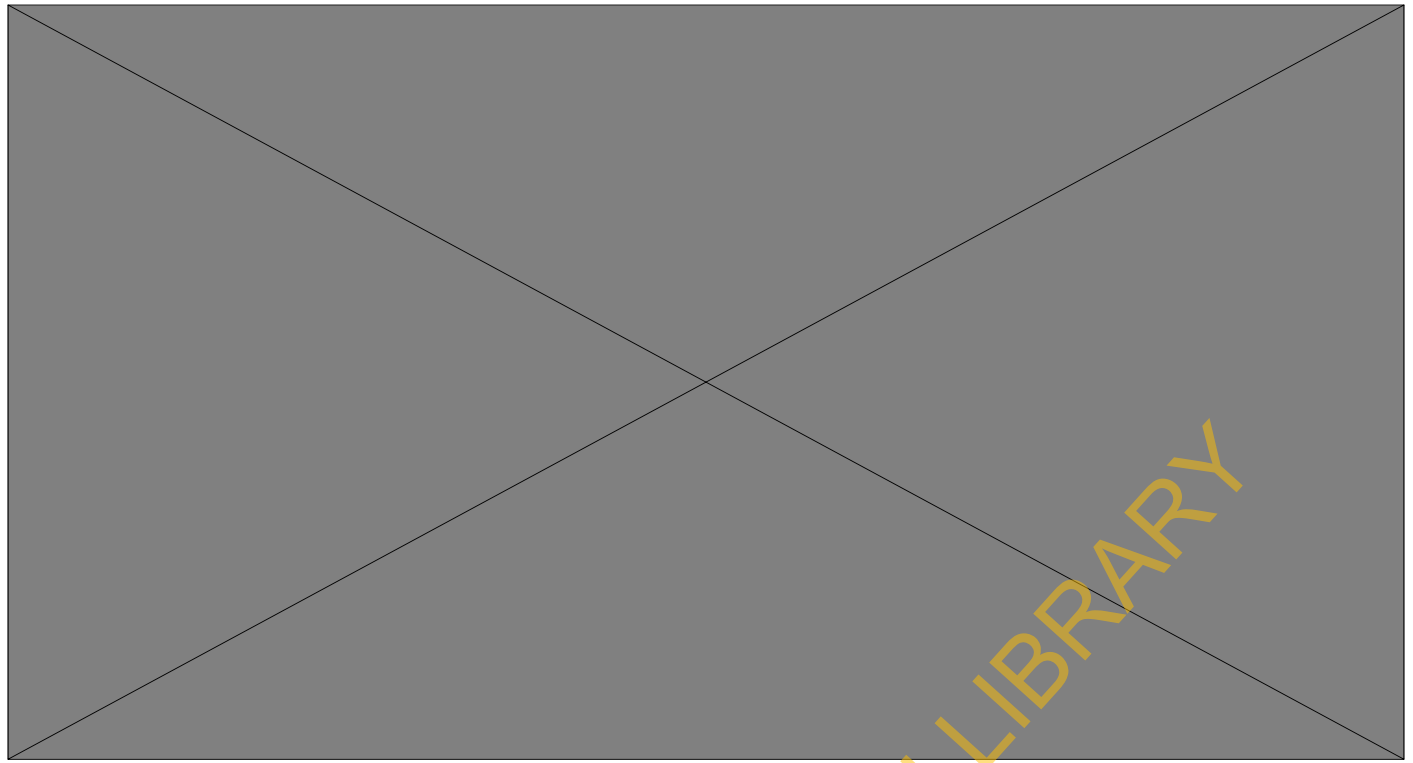
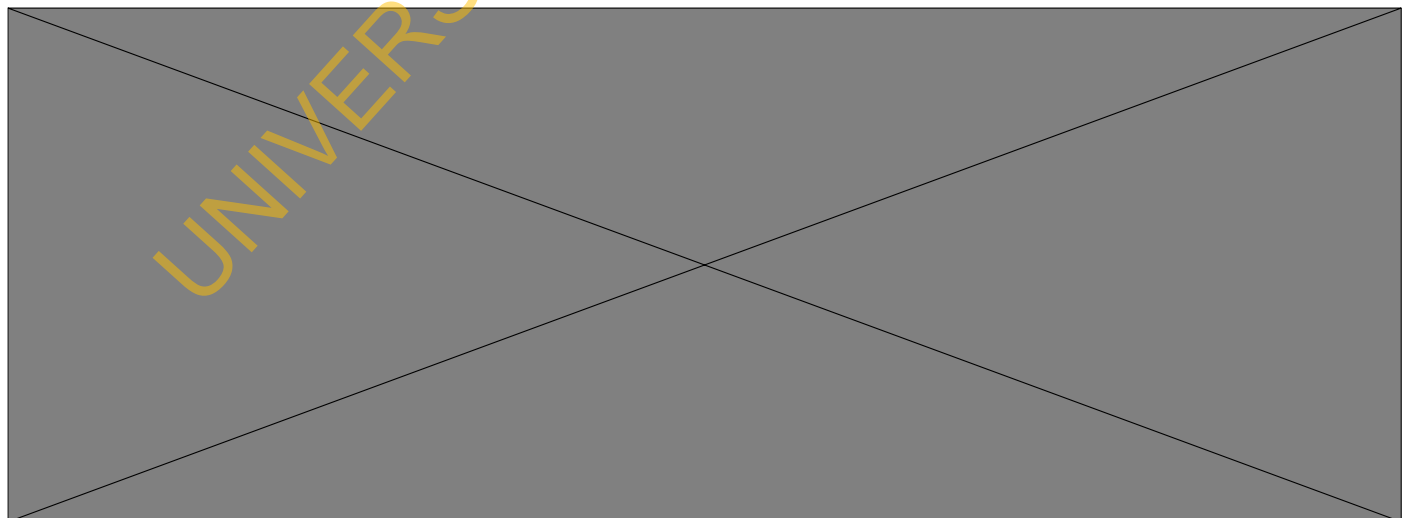


Table 3 revealed that many of the respondents who are relatively younger take more of balanced diet (vegetables and fruits, protein and carbohydrates foods) than their older counterparts. Variations in their eating habits could have been influenced by their life experiences in pregnancies. Younger women are more likely to be curious, fearful and thus likely to take precautions during pregnancies than their older counterparts. Also, younger pregnant women could have as well been more exposed to care from family members who monitor their health and food intake in pregnancy. This pattern of care cannot be said to be strange to Yoruba culture

where according to Fadipe(1991;103), there is a strong feeling of solidarity and mutual help among consanguineal and affinal relatives.

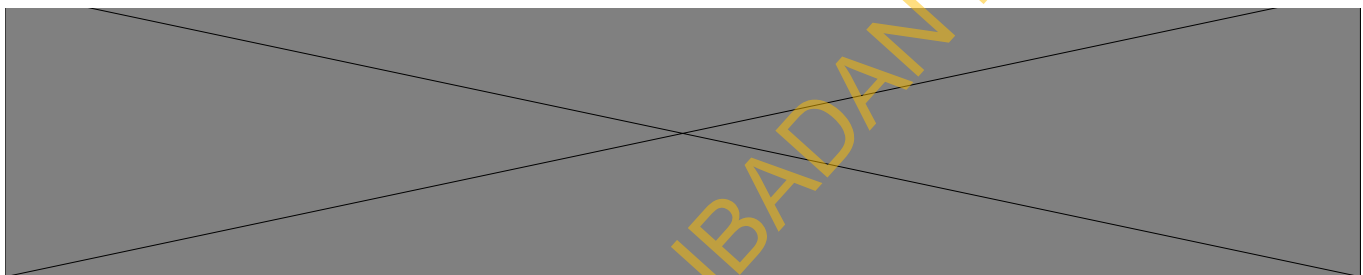
Table 4 shows that education of most of the pregnant women in the study area is significantly related to their nutritional intakes in pregnancy. It indicates that out of 171 respondents with either primary education (46) or secondary education (125), intakes of foods rich in carbohydrate is common. It can be deduced from this fact that adequate nutritional intakes as recommended by WHO for pregnant women are far from reality among people with lower level of education status.



Educational status of pregnant women maintained strong relationships with their nutritional intakes value 0.000. This opinion complements the findings of World Health Organisation (WHO, 1994) that lower educational status of women could go a long way to determine their occupational status, income level and nutritional intakes which in turn has the capacity to affect their health status, child health and at the long run their life expectancy and by extension pregnancy outcomes and general well being. Women's education in Nigeria is still low particularly in rural Nigeria where national literacy rate of women 56% and men 72% and in some states women enrolment in school is still very low (World Population Data Sheet, 2007). These facts have to a greater extent manifested greatly in the eating pattern of most of the pregnant women in the study area before and during pregnancies. This

situation however, is not likely to improve after child-birth because education contributes significantly to socioeconomic status of an individual which in turns affects their eating habits and other conditions of living. Table 5 deals with the religion of the respondents. Religion is one of the basic variables that influence every activities of an individual. In relation to nutritional intakes in pregnancy, in a study among pregnant Indian women, Ramesh (2005) observed that religion is significantly associated with eating patterns and dietary intakes of these women. He maintained that religion of an individual in his studied population is likely to make differences in diet, physical activity and socioeconomic status of women in the area. This opinion is at variance with findings among pregnant women in Ijebu East. Religion does not have any influence on dietary intakes of pregnant women. This is reflected with the chi square value of 0.872.

Table 5: Percentage Distribution of Respondents by Religion and Food Prescription in Pregnancy

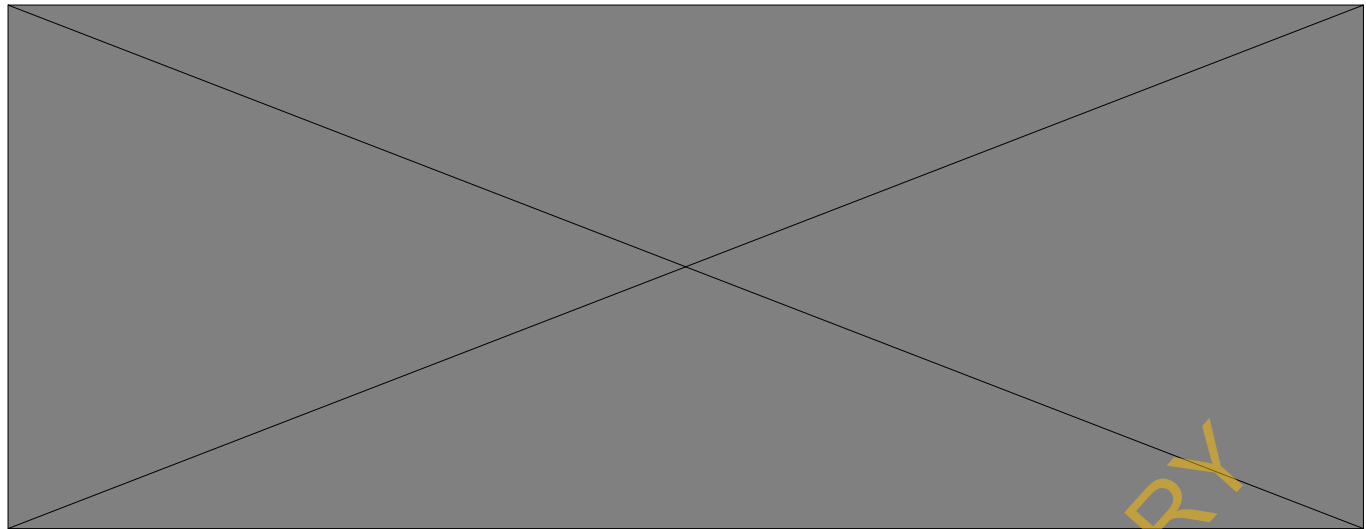


Some of the factors likely to be responsible for insignificant effect of religion on dietary intakes of pregnant women could be associated with effective medical counseling which could have convinced the pregnant women of some benefits in proper and adequate nutritional intakes during pregnancy. This finding makes one to question the commitment of the respondents to christianity and islamic religions going by the people's strong attachment to traditional belief system and practices. This was supported by the response of one of the key informants, Mrs Beatrice Sanni, 58, that : It is true we have Christians and Muslims in this community. But the issue of pregnancy and child birth is far beyond that in fact, majority of our clients are christians and muslims and I thank God that in this work I inherited from my mother I have not seen shame. They know this fact, that is why they always come here for help.(Mrs Beatrice. T .Sanni;58,a traditional birth attendant). However, in a different argument by another key informant Madam C.A. Okusanya, 60; a midwife

with Christ Apostolic Church who says: "Nutritional proscription and prescription in pregnancy cannot be devoid of religious influence either overtly or covertly".

It can then be argued from the above that a majority of Ijebu people do mix christianity and islam with tradition in the word of Nwokocha (2004) , juxtaposing the two beliefs. Though most of them profess christianity and islam, but are still strongly attached to some gods whose laws they observe.

Table 6 explored the interrelationships between income activities of the respondents and their dietary intakes in pregnancy. Income earning activities, in the word of Isiugo-Abanihe (2003), are major determinants of socio-economic status of individuals and family. To a greater extent among the studied group, income earning activities are found to have significantly influenced dietary intakes among pregnant women in the study area (value 0.000).



Though it would have been thought that in a male dominated society like the studied area, income status of women could not have been a major determinant of family socio-economic status and well-being, but with economic depression and growing inflationary trend in Nigeria, where more women are likely to be found in the workforce., women's income could no longer be regarded as complimentary to that of the husband. This finding is supported by one of the respondents Mrs Ogunsola, 45, during the FGD that "Bile ba seri loyun, a se ri, be gele lomo naa yo ri

." (That Pregnancy most times is the reflection of home situation which in turn reflects on the baby). Another key informant, Mrs Adenuga, 48, the matron in charge of Antenatal Clinic at the in General Hospital, Ijebu-Ife narrated her experience thus;

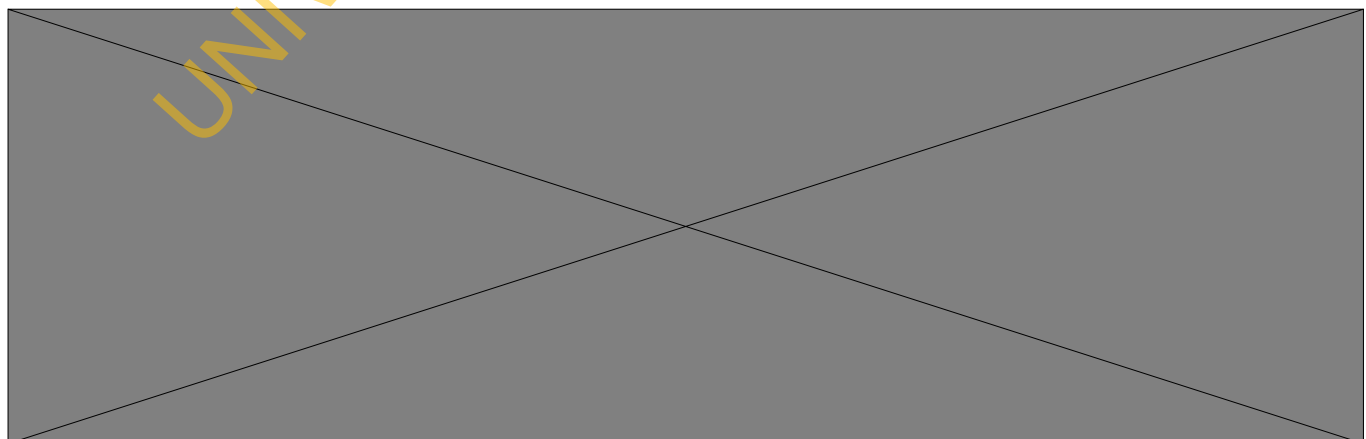
Majority of these women belong to the lower economic status and as a matter of fact their economic status reflects on their pregnancy. Though most times we teach and force them to take balanced diet in pregnancy and where we discover very serious case of under feeding

in any pregnant woman we invite the husband or close associate to the women and encourage them to ensure that such women is well catered for.

The submission above reflects the situation in the area, and this makes most of these women to engage in economic activities to support their family usually on meagre income. This to a greater extent has equally manifested through their late registration for Antenatal Care and consistent patronage of the Traditional Birth Attendants in the area which could affect pregnancy outcomes and life expectancy of most women in the area.

Table 7 presents the data on respondents' duration of marriage and their nutritional intakes in pregnancy. The study also found out that regular intake of diet during pregnancy is critically influenced by respondents' years of marriage. Among the studied groups, as respondents advanced in marital age, dietary intakes in pregnancy follow their regular eating pattern before the pregnancy. Women, whose years of marriage are relatively younger tend to be more careful, take to medical counsels and in the long eat diet which contained more nutrients than diet of their older counterparts.

Food proscription in pregnancy



Among women in Ijebu-East, marriage usually begins from 18 years of age, except among those without any formal education who married earlier. Thus, respondents with marital experiences ranging from 1-5 years appear to eat diet rich in protein and take more fruits than their counterparts with longer years of marital experience. Variations in their nutritional intakes could be linked to experiences through the process of procreation which most times could affect their adherence to medical counseling particularly on dietary intakes in pregnancy and social supports from family and members of similar religious circle. Differences in dietary intakes of pregnant women in line with their marital duration was accounted for by one of the key informants. Madam C.A. Okusanya, 60; a midwife with Christ Apostolic Church that:

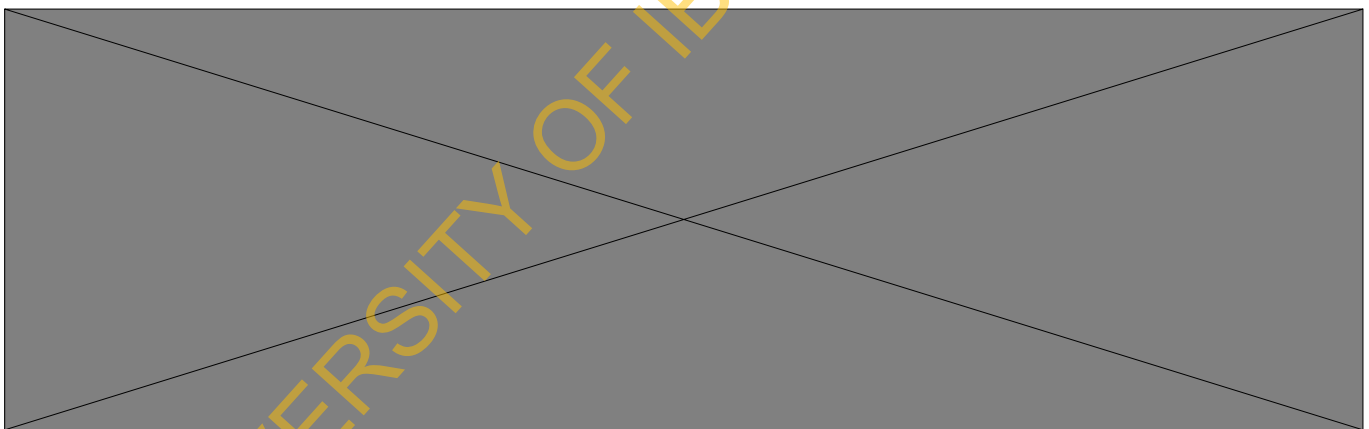
We observe that women who have recorded higher number of child births tend not to improve on their dietary intakes in pregnancy as those with fewer number of children and as such we encouraged and sometimes monitored them to improve on their dietary intakes in

pregnancy knowing fully well that the body ages gradually as fertility increases.

Following Madam C.A. Okusanya's submission, dietary intakes among pregnant women of higher duration of marriage could have been influenced among other things by psychological and social factor which could come in form of anxiety about food supply, stress associated with trying to meet daily food needs, unbalanced diet, reliance on a few kinds of low-cost food, having to acquire food through socially unacceptable means such as charitable assistance, buying food on credit, and in some cases, stealing. (http://www.toronto.ca/health/children/pdf/fsbp_ch_4.pdf)

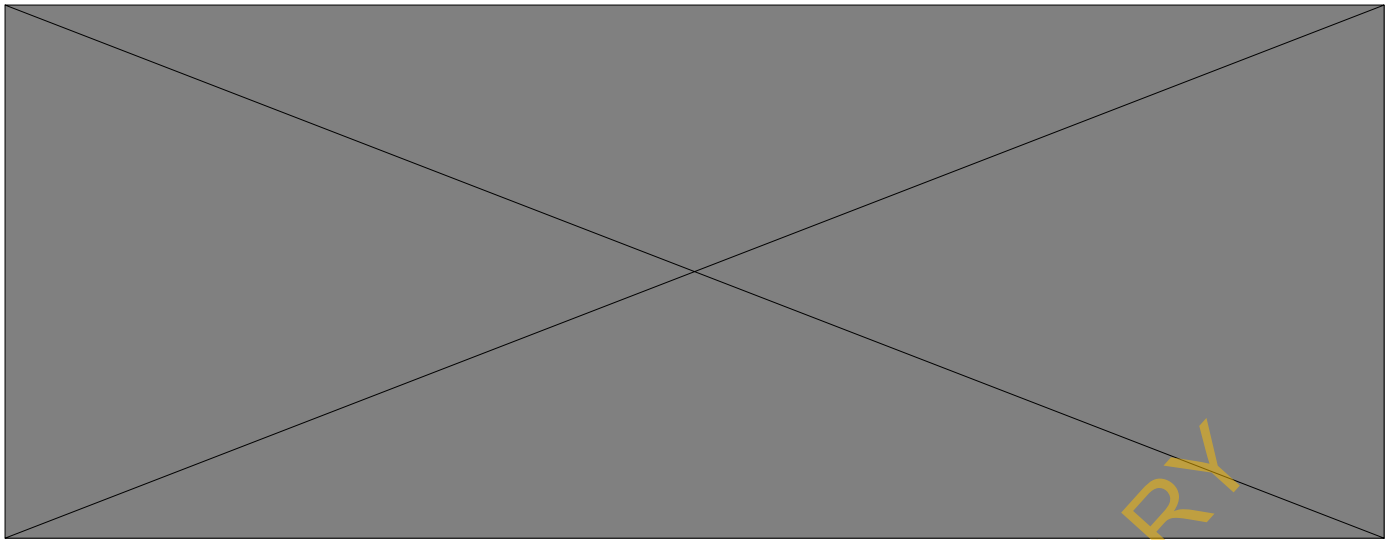
Table 8 shows the relationships between respondents number of child birth and their dietary intakes. The number of life births per respondents is found to have significant relationships with their nutritional intakes. The study found out that pregnant women with life birth ranging from 1-3 recorded more intakes on proteinous foods and fruits as well as vegetables which are required food intakes in pregnancy than their counterparts with life births of between 4-6 children.

Table 8: Percentage distribution of respondents by living number of children and food prescription in pregnancy



Apart from number of life births, the choice of health promoting life style among pregnant women have a long lasting implication on their health and that of their unborn baby(ies). As the number of children increases,

women are likely to be more concern about their welfare. This is evident in Table 8 where pregnant women with lower number of life births take more fruits and protein than their counterparts who have higher number of children ranging from 4-6.



Food proscriptions and prescriptions in pregnancy are function of the cultural practices of the people. This is relative to any human society. From the study groups, neighbours, friends and co-workers appeared to have greatly influenced dietary intakes of pregnant women in the area. About 43.2% of the pregnant women attributed their avoidance of particular foods to their neighbour, friends or co-workers. This to a greater extent has capacity in preventing pregnant women from having necessary nutritional intakes in pregnancy. For example, a pregnant woman who has been told to avoid slimy foods like okro and snails has some of her sources of iron and protein reduced or cut off. This is further compounded by the fact that such women are not advised to eat other alternative foods of equal value.

A critical look into dietary intakes of pregnant women in Ijebu-East revealed that food requirements during pregnancy are drastically different from a normal well-balanced diet. Nutrient needs are not higher, but the general principles of sound nutrition variety, and moderation still apply. Though, most of the respondents attributed none intake of carbohydrate to medical advice; this is not to claim that foods with carbonhydrates are absolutely absent from their daily meals.

In a different argument, taste and health status of pregnant women can also be regarded as other fundamental factors which determine dietary intakes in pregnancy. This view compliments responses from one of the respondents during the Focus Group Discussion that my pregnancy before this very one gave me serious problem As I could not eat and this resulted into me been

admitted for days in the hospital with series of blood transfusion. That is why I have really thought it hard now that I must eat well to prevent this occurrence of that experience(R1).

This view revealed the fact that inadequate dietary intakes in pregnancy have affected maternal outcomes in the area. Traditionally, pregnant women in the study area are mandated to eat some locally prepared concoction so as to improve on their appetite, health and that of their unborn baby (ies).

Other variables found to have influenced dietary intakes of pregnant women in the study area are presented in table 5 below. From the table, religion has been able to modify eating pattern of their adherents. In most religious houses in the recent times, health counseling had been incorporated into teaching of members (Nabofa,1996). This, had by implication been extended to pregnant women in most congregations and by extension reflected on foods to be avoided in pregnancy. In the same pattern, age of the respondents is a factor in choice of foods in pregnancy. Age of the respondents is another determinant of foods to avoid in pregnancy. From the study, younger pregnant women appear to be more selective in their choice of foods in pregnancy. By implications, they are likely to be guided by parents, mothers-in-law, neighbours and sometimes members of same religious organization who due to their privileged positions are likely to dictate foods to be eaten and those to be avoided based on their experiences. This scenario is likely to be experienced more among women who are having their first pregnancy as older pregnant women are not likely to be exposed to similar experience.

Education confers social status on individual and has ability to determine their life chances (Isiugo-Abanihe, 2003). Education of respondents in the study appeared to affect their choice of foods in pregnancy. For example respondents with lower educational status (primary and school certificate) failed to include at least a cup of milk in their diet which is one of the key foods recommended for daily consumption of pregnant women by the International Food Information Council Foundation (<http://ifc.org>). Avoidance of foods in pregnancy among these women is by extension equally influenced by their income earning activities vis-à-vis the number of children they have had and previous pregnancy experiences.

In all responses serving husbands' food before to any other member of the family appears to be the leading order in every household in study area. Explanation for this was attributed to the headship role of men in the family. By their headship position, men are the dominant decision-makers within the family; they gain socially and economically from having large number of children, wives. Their reproductive preferences and motivations influence their wives (Isiugo-Abanihe: 2003, Alliyu

2004). Responses during the Focus Group Discussion concur to the notions above. Accounting for the rationale behind the order of food serving some of the women noted that

Since the husband is the head of the home he must be catered for before any other member of the family, pregnancy condition of women notwithstanding (FGD)

The implication of the above is that better parts of the food are likely to be given to the husband and children while the woman will be left with the remaining. It is important to note that apart from order of dishing foods at home, foods are likely to be prepared in line with delicacies of the family head. Some of the respondents are asked if they will prepare and eat any food disliked by their husband even when such foods are nutritious and needed in pregnancy. The response follows thus:

If such food is forbidden by the husband such food should not be prepared in that house(FGD)

This to a reasonable extent is a pointer to the fact that food proscription and prescription in pregnancy in a function of multiple factors and significant around them is the cultural practices of the people.

Furthermore, attempts are made to find out if these women will prepare their husband delicacies which to them are forbidden to which about 97%, answered affirmatively. However the case of 'eni to leru lo leru' (i.e 'he who owns the slave owns the slave properties') among the Yoruba people is still commonplace. Moreso when women are still being influenced by cultural practices in the selection of foods to eat before, during pregnancy and lactation.

Summary of Findings

The Relationships between Cultural Factors and food intake of Pregnant Women.

The following findings are made:

1. Pattern of social relationships existing between family members like mothers-in-law, parents, siblings, affine, cognates, members of religious group and neighbours have significantly influence nutritional intakes of women during pregnancy and lactation.
2. That men's choice of foods have significantly influenced their wives' choice of foods and eating patterns, before and during pregnancy.
3. Like other Ijebu communities, there are limited culturally forbidden foods associated with pregnancy in Ijebu-East. This could however, be linked with improvements in health counseling in the area.

The Associations between Demographic Profile of Pregnant Women and their food intake

The following findings are made:

1. That Ijebu women who are relatively younger (between ages 18-30) take more nutritious foods in pregnancy than their older counterparts.
2. That duration of marriage among the people influences their dietary intakes in pregnancy. Younger couples (in marriage for 1-5 years) maintain more intimacy by eating together, attending Antenatal clinic together and thus are more conscious of their diets and health in pregnancy.
3. In a similar trend with duration of marriage, the living number of children had been found to maintain significant association with nutritional intakes of pregnancy among Ijebu women. Thus pregnant women with living children between 1-3 maintain higher food intake than their counterparts with children ranging from 4-6.

Socio-Economic Status of Pregnant Women and their Food Intake.

The following findings are made:

1. That pregnant Ijebu women that have higher educa-

tion (NCE/OND and Degree) include more fruits and protein in their diets than those with lower educational status. The implication of this is that women's education has ability to enhance maternal and reproductive health, life chances, life expectancies and thus their dietary lifestyles.

2. That respondents' income earning activities is strongly correlated to their dietary intakes in pregnancy.

3. That most pregnant women in Ijebu-East fall into the low income category.

4. That most pregnant women in Ijebu-East are economically active.

Their economic activities could be traced to their supportive roles towards family needs. This by implication, made majority of them to be economically engaged till their date of deliveries.

The Key Components of Health-Promoting Habits during Pregnancy.

1. The deep involvement of women in economic activities in Ijebu-East has resulted in their late registration for Antenatal Care. This, by implication could affect maternal and child health in the area.

2. Though the knowledge of contraceptives is high among the Ijebu people, there is a higher level of 'unmet needs' in their contraceptive behaviour. Notwithstanding they are still able to space their children.

Recommendations

To achieve any significant improvement in the maternal health and mortality, series of policies must be put in place to cater for some constraints challenging women's health some of the approaches could be:

1. Effective counseling and behavioural change communications which convinces women of the benefits of increased pregnancy consumption are, regardless of the women's circumstances, reasonably likely to increase their actual consumption before, during pregnancy and lactation.

2. Though, effective health counseling during pregnancy seems to compete with education, still the two are different. Educational attainment has the capacity to improve women's socio-economic status which in turn could determine conditions of living vis-à-vis health seeking behaviour and life expectancy. For this purpose, efforts should be made towards encouraging western education among women. An avenue can be created for adult education in rural communities in Nigeria. A policy which is yet to be actualized in Nigeria.

3. Equally important factor towards improvement of women's dietary intakes in pregnancy is the need to effectively engage men in Antenatal and Postnatal Care. This becomes imperative due to the social position of men in Nigerian and African society at large where men are at the apex of family societal hierarchy. They play an instrumental role in every aspect of sexual and reproductive dynamics from the timing of intercourse and contraceptive use to STDs treatment and antenatal care. Men function as gatekeepers to women's sexual and reproductive health because of many powerful roles they play in society as husbands, fathers, uncles, religious leaders, doctors, policy makers, local and international leaders (Isiugo-Abanihe 2003:9).

4. Also, there is a growing need to encourage cordial relationships between patients pregnant women and the medical personnel in most hospitals. Attitude of most medical personnel couple with Profession rivalry between Nurses and Medical Doctors had in the past manifested negatively on the patients which in turn has affected their health seeking behaviour (Isamah :1996). The significance of this approach is that patient experiencing challenges could be free in making their complaints known to the medical personnel. This has accounted for one of the reasons why Traditional Birth Attendants (TBA) are being patronized in rural Nigeria

5. Literature has found that changes in food-related behaviors take place more often during pregnancy than at any other stage of life (Hutter, 1996). Numerous studies have demonstrated that pregnant women need to increase food intake during pregnancy given increased energy needs associated with the growth of the foetus. For these purpose, an extension of health counselling and improved eating during pregnancy must be extended beyond the walls of hospitals to religious houses while religious leaders must be included in the counselling. This becomes relevant as religion has consistently shown significant influences on life styles of individuals.

Conclusion

Dietary intakes in pregnancy have become significant issue in demographic explanation to maternal health; this is relevant particularly when reduction in maternal mortality is one of the Millennium Development Goals (MDGs). This will by implication provide an insight into conditions of living among pregnant women in developing parts of the world and the possibilities of either reducing or

aggravating maternal mortality in the area. In a study on maternal mortality in Ile-Ife, Nigeria, Okonofua et al,1992) noted the place of socio-economic status of women, reproductive behaviour, and dietary intakes before and in pregnancy among other mechanism as determinants of maternal mortality in the area. It is then imperative from the findings of Okonofua et al to investigate further into the phenomena of dietary intakes among the rural women in Nigeria.

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