WOMEN'S AUTONOMY AND MATERNAL MORTALITY: A STUDY OF AWKA COMMUNITY, AWKA SOUTH LOCAL GOVERNMENT AREA, ANAMBRA STATE.

CHINWE R NWANNA
Department of Sociology, University of Lagos

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ABSTRACT

The objective of this study was to determine the relationship between women's autonomy and maternal mortality in Awka community, Anambra State. It is a population-based study conducted between November and December 2001. It adopted an innovative approach by combining sisterhood, widowhood, neighbourhood/friends and household history methods to collect data from a multistage systematic random sample of 1,400 men and women of reproductive age. Men were included because the researcher sought to know the interplay of power relations within the family as they affected maternal health. Data were collected through interviews and focus group discussions. Comparative and percentage analyses were used to analyze and interpret the data. The results demonstrated that 114 maternal deaths were isolated to have occurred from 1996 to 2000, the period under study with a maternal mortality ratio of 1,592 deaths per 100,000 live births in 2000. The respondents consisted of 43 males and 71 females. The deceased women would not have traveled on their own to seek healthcare, attend antenatal care (ANC) nor seek routine delivery without the permission of their husbands. At 0.01 significant level and with contingency coefficients of between 0.64 and 0.73 the relationship was strong. Therefore there is a significant relationship between women's autonomy in Awka and maternal mortality. The lower the autonomy of women the higher the ratio of maternal mortality. Recommended, among others, were enlightenment campaigns and education for men to sensitize them on the effects of gender inequity on maternal health.

Key words: Anambra state, Awka, domestic decision-making, freedom of movement, maternal mortality, women's autonomy.

1.0 INTRODUCTION

This article presents a part of the report of a study titled "Relationship between women's status and maternal mortality: A case study of Awka in Anambra State, Southeast Nigeria" funded by CODESRIA GENDER INSTITUTE 2001[1]. Several studies have been conducted to examine the relationship between women's status and fertility but not in the area of maternal mortality. Studies explicitly concerned with women's status and maternal mortality are relatively new. Most often education and employment are used to measure the status of women that they have long been at the forefront of policy recommendations aimed at improving women's status (Govindasamy and Malhotra 1996:331; Hogan et al 1999:304). Relationship between women's

[1] It is a part of a study titled "Relationship between women's status and maternal mortality: a case study of Awka in Anambra State, Southeast Nigeria" funded by CODESRIA GENDER INSTITUTE 2001.

autonomy and maternal mortality has not been studied extensively. However, some studies have demonstrated that women's autonomy is correlated to maternal mortality. The main reason provided for this is that women lack rights to make decisions (Plata, 1998). Women's reduced decision-making power and inequitable access to family and social resources prevent them from overcoming barriers to health care. In Awka, women are traditionally empowered socially, educationally and economically particularly through the "umuada" system where they have the rights to make decisions in their fathers' homes even after marriage but whether this empowers them to make domestic decisions including reproductive decisions in their husbands' homes is a question this article will address. Therefore the main focus of this report is to examine the relationship between women's autonomy and maternal deaths. Women's autonomy refers to the freedom of movement and to make independent decisions to use health facilities while maternal mortality has been defined by the International Statistical Classification of Diseases, Injuries, and Causes of Death. Ninth Revision (ICD-9) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy or its management, but not from accidental or incidental causes" (Campbell and Graham, 1991:5; Huque and Koblinsky 1991; WHO, 1992).

1.1 STATEMENT OF PROBLEM

The most recent figures from the World Health Organization (WHO) estimate that 515,000 women die annually from maternal causes (Ransom and Yinger, 2002:6), 99% of them in developing countries (UN, 1998:18; Ransom and Yinger, 2002:6). Maternal health is said to be one indicator with the highest disparity between the developed and developing countries among the public health indicators. Rosenfield and Maine (1985) have asked the question "where is the M in the MCH?" i.e. where is the maternal component in the Maternal and Child Health (MCH) of the Primary Healthcare Programme? Evidence shows that maternal mortality ratio in Nigeria is still high despite all the concerted efforts to reduce it. Estimates of the 1999 Multiple Indicator Cluster Survey (MICS) show a maternal mortality ratio (MMRatio) of 704 deaths per 100,000 live births (Hodges, 2001:39). This figure varies from one region or ethnic group to another. For instance, the maternal mortality ratio for Hausa-Fulani Muslims having no antenatal care was 3,180 deaths per 100,000 live births, in contrast with a ratio of 890 deaths per 100,000 live births among Nigerian Christians of other ethnic groups (Wall 1998). These figures are just the tip of iceberg as there is gross under-reporting of maternal mortality.

Many scholars have tried to theorize that changes in the women's status and women involvement in decision-making are the key factors to the reduction of maternal mortality. Some researchers have conducted studies focusing on the link between these factors and maternal mortality in the northern part of this country. Although the findings have generally supported this theory the evidence has not been demonstrated in Anambra state. Therefore Awka, the capital of Anambra State was chosen for the study. The objective of this report therefore, is to determine the relationship between women's autonomy and maternal deaths in Awka, Anambra state.

1.2 SPECIFIC OBJECTIVES OF THE STUDY

1 To examine the association between women's participation in domestic decision-making to use health facilities and maternal mortality.
2 To explore the extent of women's freedom of movement to use health facilities and maternal mortality.

3 To collect data on maternal deaths from 1996 to 2000 to determine the level of maternal mortality in Awka, Anambra state.

1.3 THE SIGNIFICANCE OF THE STUDY

It is hoped that the findings of this study will enrich the literature in this area and expose the extent to which the gender relations within the home affect the health status of women of reproductive age in Anambra State. The findings will contribute to the increasing awareness to the enormous problems attendant on unsafe childbirth, sensitize and stimulate feminists, policy makers, programme planners, non-governmental organizations and others to agitate and advocate for elimination of all forms of discrimination against women, equality in all spheres of life including making decisions without their husbands' consent in life saving situations. It will also stimulate further researches in this area.

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Here some of the studies already conducted in this area are reviewed. Harrison et al (1985) conducted a research in Zaria and discovered that all of the un-booked pregnant women from Zaria town who died and 82% of the un-booked pregnant women from outside Zaria who died had ready access to transportation and lived within two kilometres of an all-season road. The women delayed in seeking healthcare because in Hausaland, it is males' responsibility to determine that a woman has a serious medical problem that requires hospital care. Therefore given their position in the social hierarchy, pregnant Hausa women must have male permission to seek medical care and will usually be accompanied by their husbands or by a male relative.

In another study conducted by The Prevention of Maternal Mortality Network (1992) in rural communities in Nigeria, Ghana and Sierra Leone it was found that when a complication occurred, the decision of where to seek care depended on what was thought to be the cause of the complication in all the areas studied. Certain behaviours such as disregarding the authority of one's husband or elders were believed to lead to obstructed labour. Furthermore, the results reveal that women in seclusion or "purdah" were not allowed to leave the family compound and would ask their husbands' permission to seek treatment when the need arose. The findings were supported by the findings of Mother Care Project (1992) and Thaddeus and Maine (1994). WHO (1999:15 and 2000:2) opines that maternal mortality and morbidity result from social, economic and gender dynamics deeply rooted in family systems, and societal institutions.

There are three main schools of thought that are reviewed here namely demographic, sociological and feminist perspectives. A variant of the demographic theory is the empowerment perspective. It presumes that the fundamental factor associated with maternal mortality is the low value placed on the lives of women (Shiffman, 2000:277). The most important point is where their lives are valued; women are more likely to have access to education, from which numerous benefits accrue. They may be more inclined to seek antenatal care and be more willing to choose trained medical personnel to assist them during delivery, rather than traditional birth attendants. This theory also has been faulted. A major critique here is Maine (1993:25). She argues that empowerment perspective may not necessarily reduce maternal deaths to any substantial degree therefore sociological explanation is explored.

Others have provided a sociological explanation to maternal mortality. They argue that women's oppressed position is associated with maternal mortality. The orthodox Marxist argue that women's oppression is a function of class oppression that supercedes all other forms of oppression and is explained in terms of their class location, with respect to ownership and control of the means of production and position in the labour force. The husband is the bourgeoisie and wife a proletariat within the context of the family (Ityavyar and Obiajunwa, 1992:23). Women's oppressed position therefore denies them access to economic, social, political, and health care services. Their lack of economic resources constrains their ability to make independent health-related choices and to gain access to health and other social services.

From the Marxist perspective another set of theories, feminist theories developed. The main theme of the feminist theories is that women, right from birth are relegated to the inferior position and discriminated against in access to education, social, economic, health and political opportunities. Applying this theory to the women's autonomy and maternal mortality, pregnant women do not usually have the right to the freedom of movement and seeking healthcare services when the need arises. They usually seek permission from their husbands before using healthcare facilities. From this theoretical vantage point the paper adopts a framework.

The study is based on the analyzing framework developed by McCarthy and Maine (1992) and modified by Tinker and koblinsky (1993). Tinker and koblinsky (1993) presented a four-tiered framework of analysis starting from the contextual distant factors like women's status to intermediate factors such as maternal age, health and reproductive status, use of health facilities etc, through proximate factors to maternal morbidity and mortality outcomes. The argument behind this framework is that any improvement in the status of women affects the maternal transition from high to low levels through the sum of its effects on intermediate and proximate variables that are related directly to maternal mortality. Sequel to the above the following hypotheses are then formulated:

1. The greater the women's participation in decision-making to use health facilities the lower the ratio of maternal mortality.
2. Women's freedom of movement to use health facilities is inversely related to maternal mortality.

3.0 METHODOLGY

The study was conducted in Awka, the capital of Anambra State with a population of 58,225 (National Population Commission (NPC) 1998). Population of males and females of reproductive age i.e. between 15 to 49 years is 28,006 (NPC, 1998). There are 33 patrilineal villages in Awka. The people are organized according to compatible groups, age grades and tightly knit organizations. The people are predominantly Igbos comprising of civil servants, farmers, traders and industrialists. Awka has a general hospital that provides secondary referral level care. It has other public health facilities such as health clinics, MCH clinics and dispensaries that make up the primary health care level. Public health facilities lack basic infrastructures and utilities and are mostly dilapidated structures. Awka has a good concentration of private hospitals and clinics about 22 in number.

Maternal mortality is a rare event therefore for manageability, cost and convenience five percent of the population of men and women of reproductive age in Awka was computed and used. Data

were collected from a multistage systematic random sample of 1,400 men and women of reproductive age using interview method complemented by focus group discussions (FGDs). Men were included because the researcher sought to know the interplay of power relations within the family as they affected maternal health. Awka has a combination of traditionalism and modernism. When a death occurs every adult, irrespective of the sex, is expected to pay a condolence visit individually and in groups because every body belongs to one or more groups. During the visits, usually the cause of the death is announced particularly if the death occurs as a result of pregnancy related complications. For this reason therefore a combination of sisterhood, widowhood, neighbourhood/friend and household history methods was found useful in gathering information about maternal deaths. At the end of the interview exercise that spanned from 13th November to 20th December 2001, the questionnaires were sorted out, screened and checked for non-responses or completion. All deaths that occurred outside the 5-year period under review were not included. Also deaths due to accidents, fights or falls etc were not included. After a thorough sorting 114 maternal deaths were identified to have occurred during the 5-year period under review. Only these 114 questionnaires were analyzed since the research was interested in the correlation between maternal deaths and women's autonomy. Statistical Package for Social Sciences (SPSS), comparative and percentage analyses were used to analyze and interpret the data. One major problem encountered during the fieldwork was the issue of recalling what happened before the deaths. The questions recalled sad memories that made some respondents become emotional that they broke down and would not continue with the interview despite all persuasions. They could not see the need to study the causes of the deaths since the deceased would not be resurrected. It was observed that the respondents were freer or more comfortable talking about neighbours and friends than sisters or wives.

4.0 FINDINGS

The findings reveal that 43 (37.7%) men and 71 (62.3%) women were identified among the 114 accepted questionnaires. The mean age of the respondents was 32 years. Majority of them had formal education, (50%) had secondary education while 34.2% had tertiary education. One-half of them (51%) were married, 31% civil servants and (17.5%) were traders. More than half of them had income less than N10, 000 per month while 20% had no income. The respondents were more of Catholics and Anglicans 53% and 24% respectively.

4.1 Identification of maternal deaths

The methodology used in this study was a combination of sisterhood, widowhood, friends neighbourhood, and household history methods. This combination was very useful because it was possible to identify many maternal deaths which would have been missed if only one single method e.g. sisterhood method was employed. About 251 maternal deaths were identified 24 sisters, one wife and 226 neighbours and friends who had reached age 15 (see table II below). But most of them occurred outside the five years under study, outside Awka community and for some complete information were not provided and therefore they were not included in the analysis. The analysis was based on 114 maternal deaths that occurred within Awka community and within the stipulated period under review i.e. between 1996 and 2000.

Table II highlights the total deaths of women during pregnancy, delivery and within six weeks after delivery for the five years before the study (1996-2000). To compute the maternal mortality ratio for Awka the figure for 2000 i.e. 25 (21.9%) was used because it was the latest within the

last one year before the study. Maternal mortality ratio of 1,592 maternal deaths per 100,000 live births was computed using the total number of live births, 1570[2] for Awka in the same year.

4.2 Socio-demographic characteristics of the deceased women.

Table III demonstrates that the mean age of the deceased women at death was 28 years, 76.3% were married and 16% never married. The respondents could not tell the ages at marriage of most of the deceased hence ages of about 41% were not indicated. Their mean age at marriage was 24 years. More than three-fifths of the deceased (64%) had secondary education. The occupational status of the deceased women revealed that a colossal number (81%) were housewives, traders, students, farmers and businesspersons which suggests that they did not earn steady income. About 60% earned less than N10,000 per month. Therefore they were of low - income group. Therefore in Awka community, women who did not earn steady income and of low income have the tendency to die during pregnancy, childbirth and abortion.

4.3 Use of health facilities

About three-quarters (75%) of the deceased women were reported to have attended ANC (see table IV). When asked to state if it was decided to seek care when complications developed either during pregnancy, delivery or within 6 weeks after delivery 10% did not decide to seek care and the major reason provided was inconvenient time (36%). This shows that lives of women are not valued. Even among those who decided to seek care, significant proportions (53%) husbands and (13%) husbands' relations made the decisions (see table IV). This suggests that women in Awka do not have the rights to make decisions about their reproductive health and therefore are more likely to die during pregnancy, delivery or within 6 weeks after delivery.

4.4 Women's autonomy.

The main concern of this report is to know whether the women had the right to make decisions concerning their health and whether they could decide on their own to attend antenatal care (ANC), visit hospitals when complications arose and when in labour without waiting for their husbands' permission. Therefore in order to achieve this, women's autonomy was measured by women's participation in decision-making and freedom of movement to use health facilities. Each of these variables was further measured by three variables. For example, participation in decision-making was measured by asking the respondents whether the deceased women could have asked for permission to seek health care, attend ANC and seek routine delivery. Freedom of movement was subsequently measured by asking whether the women could travel on their own to seek health care, attend ANC and seek routine delivery.

Here it was necessary to compare the responses of males and the females to see how they varied and how they affected the lives of women in Awka. In the table V, 28 (25%) respondents agreed that the deceased women would have asked for permission to seek health care though 66% did not agree. More women than men subscribed that the deceased women would ask for permission from their husbands to seek healthcare, attend ANC and seek routine delivery. Unlike the reaction to asking for permission, where fewer number of respondents said the women should ask for permission, significant proportions of the respondents reported that the women would not have traveled on their own to seek health care (40%), attend ANC (36%) and seek routine delivery (57%). More men than women opined that the women could not have traveled on their

[2] Source: National Population Commission, Awka.

own to seek health care, routine delivery and attend ANC. Therefore pregnant women in Awka cannot make independent decisions nor have freedom of movement to use health facilities. These findings support earlier studies by Harrison et al (1985), Nakajima (1988), The Prevention of Maternal Mortality Network (1992) and Mother Care Project (1993), Thaddeus and Maine (1994) and Plata (1998). They also confirm empowerment, Marxist, feminist theories and the theoretical framework.

4.4 Testing of hypotheses

In testing the hypotheses, Chi-square (X^2) statistical method was employed. This is to test the stated research hypotheses whether they are true or false and also confirm or negate the above findings. Where the relationships found were highly significant, contingency coefficient was computed to know the strength of the relationships.

HYPOTHESIS I: The greater the women's participation in domestic decision-making to use health facilities the lower the ratio of maternal mortality. NULL HYPOTHEIS: There is no relationship between women's participation in domestic decision-making to use health facilities and maternal mortality. The calculated Chi-squares (X^2s) for the three variables ranged between 111.6 and 129.4 and were greater than the table X^2 of 11.341 at 0.01 significant level and degree of freedom of 3 and therefore the null hypothesis was rejected and the research hypothesis accepted. Strong positive relationships were found with contingency coefficients of between 0.70 and 0.73. Therefore there is a significant relationship between women's participation in domestic decision-making to use health facilities in Awka and maternal mortality. The greater the women's participation in domestic decision-making to use health facilities the lower the ratio of maternal mortality

HYPOTHESIS II: Women's freedom of movement to use health facilities is inversely related to maternal mortality. NULL HYPOTHEIS: There is no relationship between women's freedom of movement to use health facilities and maternal mortality. Also here calculated X^2s ranged from 80.6 to 91.3 and were greater than the table X^2 of 11.341 at 0.01 significant level and degree of freedom of 3 and therefore the null hypothesis was rejected and the research hypothesis accepted. With contingency coefficients of 0.64 - 0.67 their relationship was strong. Therefore women's freedom of movement to use health facilities is inversely related to maternal mortality. These findings confirm the findings of the descriptive analysis above.

6.0 DISCUSSIONS AND RECOMMENDATIONS

The analysis of findings provides important insights into the relationship between women's autonomy and maternal mortality. Although the relationship is complex, some patterns emerged that have theoretical and policy implications.

First, the findings show that maternal mortality ratio in Awka was quite high (1592 deaths per 100,000 live births in 2000) despite the introduction of Safe Motherhood Initiative since 1990. The implication is that the programme has not been effective therefore there is need to re-strategize the programme. Probable reason for this high ratio could be that the women were not patronizing the public health facilities. This might probably be due to poverty, exorbitant hospital fees, dilapidated facilities or nonchalant attitudes of the hospital workers and inadequate

equipment in these hospitals or that the personnel are not remunerated well enough to motivate them.

Second, the lives of women in Awka are not valued. Husbands and their relations made the decisions concerning reproductive health even in live saving cases. This was supported by the findings of the FGDs where mothers-in-law were reported to be the ones determining when to use health facilities and the type of facilities to use. Instances were given where they prevented their daughters-in-law from going for ANC or going to the hospital to deliver when the need arose. Education and enlightenment campaigns should be organized for men and women particularly the older generation for the to know the importance of ANC and all other needs of the pregnant women.

Third, It was discovered that the deceased women would have asked for permission to seek health care. One would have expected that the contrary would be the case as most of the women were educated to the secondary and tertiary school levels. Education is considered to improve women's ability to resist subjugation and to acquire greater power in decision-making but that seems not to apply in this case. Evidence suggests that power, input or freedom for women in one sphere may not correspond with a similar status in another sphere (Govindasamy and Malhotra, 1996:330). Education may have empowered them to other areas and not in making decisions concerning their reproductive health. The findings do not support the empowerment theory but support the Marxist and the feminist theories. Furthermore, more women than men indicated that dead women should have asked for permission before seeking or using health care facilities. This finding reflects what happens in the larger society where women themselves believe that men's permission, as 'the heads of families', must be obtained before embarking on any activity. Significant proportions of the respondents believed that the women would not have traveled on their own to seek health care, attend ANC, and seek routine delivery. Contrary to the finding of asking for permission, more men than women opined subscribed that the deceased women could not have traveled on their own to seek health care, routine delivery or attend ANC. Here men were reaffirming male supremacy that women should not travel on their own. It may be because it involves giving out transport fares to their wives in situations where the hospitals are far. In Igboland it is the responsibility of the man to take care of the pregnant wife no matter how educated and economically independent the wife may be.

The findings of FGDs did not support the findings of the descriptive analysis. The male participants claimed that the women did not need their permission to seek healthcare or attend ANC because they would not want complications. One of the men said, ***"it is even the husbands who urge their wives to visit the hospitals because they don't want trouble".*** The female participants asserted that this depended on the individual man. ***"Not all men allow their wives to do so. Some enlightened men would give their wives every support and permit them to visit the hospitals for ANC and delivery"*** said one of the female participants. She added further that some men would not permit their wives to attend ANC or deliver in the hospitals. They determined the hospitals to be used by their wives. In this case the men would recommend those facilities their wives would not want to use e.g. private maternity homes where the fees are cheaper but are most of the times manned by the traditional birth attendants (TBAs). Consequently the women will be denied the use of healthcare facilities since their husbands will not permit them to use any other one. The men expected their wives to have the same reproductive behaviours as their

mothers who had many deliveries without complications. They felt the present day wives were lazy and spoilt. The men reiterated that a traditional Awka woman was empowered socially, educationally and economically and therefore did not require taking permission from the husband before visiting any hospital after all it was her life, they concluded. The men might probably be painting a "holier than thou attitude" and wanted to impress the researcher because in reality it is not so. The female participants did not agree totally with the men's opinion. While some supported the men, others maintained that no matter the level of the empowerment of the women some husbands still refused their wives to attend ANC or visit hospitals for delivery. These discussions therefore support the findings above where more women indicated that women would have asked for permission before using health services.

The testing of the hypotheses revealed that the greater the women's autonomy the lower the ratio of maternal mortality. Comparing the two findings of Chi-squares (X^2s) and contingency coefficients those who subscribed to obtaining permission were far greater than those who subscribed to freedom of movement. What this means in essence is that women are still subordinated to men irrespective of their educational status. This goes a long way to demonstrate that in Africa and Nigeria in particular education alone may not contribute substantially to women's empowerment unless it enables them to find income generating activities. Women's employment is considered to be an important factor in enhancing their status. Working-women particularly those who earn cash incomes, are presumed to have greater control over household decisions, increased awareness of the world outside the home, and consequently, more control over reproductive decisions (Gage, 1995). The findings revealed that most of the women were not gainfully employed and could not therefore have control over household decisions including reproductive decisions. In Awka community therefore women do not decide or have freedom of movement to use health facilities just like in any other patriarchal society. Most societies, both developed and developing, are patriarchal where men are the heads of families and take decisions including those of maternal health. The only difference is that in developed countries women's lives are valued and where their lives are valued their status is more likely to be high. The low social status of women in some countries limits their access to economic resources and education. This in turn limits their ability to make decisions about their health and nutrition. The policy implication here is that enlightenment campaigns and education should be organized for men to sensitize them on the effects of gender inequity on maternal health. They should be involved in any programmes being organized for the women including family planning. Government's performance in Anambra state is below expectation therefore good spirited people and Nom-governmental organizations are called upon to provide poverty alleviation programmes for the women. Employment opportunities should be created for the women.

Table I: Identification of maternal deaths

Number of sisters ever born of the same mother	N	%
None	9	7.9
1	12	10.5
2	20	17.5
3	22	19.3
4	27	23.7
5	7	6.1
6	9	7.9
7	5	4.4
8	1	0.9
Missing	2	1.8
Total 358	114	100
Number of sisters that were dead		
None	85	74.6
1	19	16.7
2	8	7.0
4	1	0.9
Missing	1	0.9
Total 39	114	100
Number of sisters that died :		
During pregnancy	8	20.5
During delivery	8	20.5
Within 6 weeks of delivery	8	20.5
Other types of death	15	38.5
Total	39	100
Number of wives ever married by respondents		
None	18	41.9
1	22	51.2
2	1	2.3
4	1	2.3
Missing	1	2.3
Total	43	100
Number of wives that were dead		
None	22	88.0
1	2	8.0
Missing	1	4.0
Total	25	100
Number of wives that died		
During pregnancy	0	0.0
Duringdelivery	0	0.0
Within 6 weeks of delivery	1	50.0
Other deaths	1	50.0
Total	2	100
Knowledge of any female neighbours or friends who reached age 15 and had died.		
1. Yes	108	94.7
2. No	6	5.3
Total	114	100
Number of friends/neighbours who died while pregnant		
None	47	43.5
1	33	30.6
2	17	15.7
3	10	9.3
5	1	0.9
Total 102	108	100
Number of friends/neighbours who died while delivering		
0	48	44.4
1	46	42.6
2	8	7.4
3	6	5.6
Total 80	108	100
Number of female neighbours/friends who died within 6 weeks after the end of pregnancy		
0	72	66.7
1	31	28.7
2	3	2.8
3	1	0.9
4	1	0.9
Total 44	108	100

Table II: Identification of maternal deaths by year

Year	No.	%
1996	11	9.6
1997	18	15.8
1998	30	26.3
1999	30	26.3
2000	25	21.9
Total	114	100

Table III: The socioeconomic characteristics of the deceased

N=114 Age	No.	%
1. 15-19	9	7.9
2. 20-24	17	14.9
3. 25-29	38	33.3
4. 30-34	16	14.0
5. 35-39	13	11.4
6. 40-44	7	6.1
7. 45-49	5	4.4
8. Don't know/missing	9	8.0
Mean age = 31..53years		
How old was name when she got married?	No.	%
15-19	8	7
20-24	31	27.2
24-29	15	13.2
30-34	12	10.5
35-39	1	0.9
40-44	0	0
45-49	0	0
Don't kn/missing	47	41.2
Marital status	No.	%
1. Never married	18	15.8
2. Married	87	76.3
3. Divorced	4	3.5
4. Separated	2	1.8
5. Don't know	3	2.7
Educational level	No.	%
1. No formal education	7	6.1
2. Primary	10	8.8
3. Secondary	73	64.0
4. Tertiary	21	18.4
5. Others	1	0.9
6. don't know/missing	2	1.8
Occupational status	No.	%
1. Housewife	29	25.4
2. Farmer	6	5.3
3. Trader	34	29.8
4. Student	13	11.4
5. Businessperson	10	8.8
6. Civil servant	21	18.4
7. Professional	1	0.9
Monthly income	No.	%
1. None	34	29.8
2. Less than N5. 000	17	14.9
3. N5, 001- N10. 000	17	14.9
4. 10, 001- 15. 000	14	12.3
5. 15, 001- 20. 000	7	6.1
6. 20, 001- 25. 000	2	1.8
7. Don't Know	23	20.1

Table IV: Use of Health Facilities

Did name attend ANC?		
Yes	86	75.4
No	25	21.9
Don't know	3	2.6
Reasons for not attending ANC		
Too far	3	12.0
Inconvenient time	2	8.0
Poor services	1	4.0
Rude staff	2	8.0
Dilapidated facilities	1	4.0
Could not afford bill	9	36.0
Received home visits	1	4.0
Husband forbade	1	4.0
Family forbade	1	4.0
Too busy	1	4.0
Nobody to look after	2	8.0
Others	1	4.0
Total	25	100
When a problem developed was it decided to seek care?		
Yes	97	85.1
No	11	9.6
Don't know	6	5.3
Total	114	100
If yes, who made the decision?		
Name	20	20.6
Husband	51	52.6
Husband's relation	13	13.4
Friend	4	4.1
Others	6	6.2
Don't know	3	3.1
If no why? Reasons for not deciding to seek care		
	No.	%
Inconvenient time	4	36.4
Could not afford the bill	3	27.3
Did not know where to go	2	18.1
Husband forbade	1	9.1
Family forbade	1	9.1
Total	11	100

Table V: Women's autonomy

		MALE		FEMALE		TOTAL	%
Could she Ask for permission to :	Response	No.	%	No.	%	No.	%
Seek health care?	Yes	7	16.7	21	29.6	28	24.8
	No	29	69.0	45	63.4	74	65.5
	DK	5	11.9	4	5.6	9	8.0
	NA	1	2.4	1	1.4	2	1.8
	Total	42	100	71	100	113	100
Attend ANC?	Yes	8	19.0	18	25.4	26	23.0
	No	31	73.8	47	66.2	78	69.0
	DK	3	7.1	3	4.2	6	5.3
	NA	-	-	3	4.2	3	2.7
	Total	42		71		113	
Seek routine delivery?	Yes	7	16.7	20	28.2	27	23.9
	No	32	76.2	46	64.8	78	69.0
	DK	3	7.1	2	2.8	5	4.4
	NA	-	-	3	4.2	3	2.7
Could she travel to:							
Seek healthcare?	Yes	17	40.5	44	62.0	61	54.0
	No	22	52.4	23	32.4	45	39.8
	DK	3	7.1	1	1.4	4	3.5
	NA	-	-	3	4.2	3	2.7
Attend ANC?	Yes	18	42.9	45	63.4	63	55.8
	No	20	47.6	21	29.6	41	36.3
	DK	4	9.5	2	2.8	6	5.3
	NA	-	-	3	4.2	3	2.7
Seek routine delivery?	Yes	9	21.4	26	36.6	35	31.0
	No	27	84.3	37	52.1	64	56.6
	DK	6	14.3	6	8.5	12	10.6
	NA	-		2	2.8	2	1.8

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