Background of the Study

Maternal Mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any course related to or aggravated by the pregnancy or it management but not from accidental or incidental causes (World Health Organisation (WHO), 2009). The scale of worldwide maternal death is shocking. The United Nations Population Fund (UNFPA) in 2008 records that one woman dies in childbirth every minute, with over half a million women dying per year. Most of these deaths can be prevented. Preventable maternal death and disability are increasingly recognized as pressing human rights issue, encompassing questions of resource allocation and political commitment, for which governments must be held accountable. The situation in Nigeria illustrates the importance of government accountability in effectively reducing maternal death. With a population of over 140 million, Nigeria is the most populous country in Africa and the tenth most populous in the world (National Population Commission (NPC), 2007). The incidence of maternal death in Nigeria is one of the worst in the world (CIA, 2008). Resources alone do not automatically translate into a reduction in maternal death. The World Health Organization in 1999 identified long-term political will or commitment as an indispensable factor for the reduction of maternal death. This means that governments and decision makers must develop adequate laws, policies, and measures, and must ensure their execution by making the necessary funds available. Likewise, they must implement international and regional laws and policies that impact on maternal health. While the Nigerian government has ratified most relevant international and regional treaties and has developed policies aimed at improving reproductive health, including maternal health, these actions have not translated into effective implementation and resource allocation. The number of maternal deaths in Nigeria which is 545 maternal deaths per 100,000 live births is second only to that of India (Centre for Disease Control (CDC), 2007). The majority of these maternal deaths, as in the rest of the world, are preventable, and while the causal factors can be multiple and complex, governments must be held accountable when their actions or inaction contribute to this ongoing loss of women's lives. WHO in 2007 also identifies Nigeria as having the world's second-highest number of maternal deaths with approximately 59,000 of such deaths taking place annually.

While the Nigerian government has repeatedly identified maternal mortality and morbidity as a pressing problem and developed laws and policies in response, these actions have not translated into a significant improvement in maternal health throughout the country. A number of factors inhibit the provision and availability of maternal health care in the country and these include lack of implementation of laws and policies, the prevalence of systemic corruption, weak infrastructure, ineffective health services, and the lack of access to skilled health-care providers. Nigeria's national government is divided into three distinct tiers: the federal, the state, and the local governments. The 1999 Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities. This omission has resulted in overlaps and uncertainty regarding the division of these obligations, which has enabled each level of government— particularly the local tier—to shirk its duties in this regard (Health Reform Foundation of Nigeria (HERFON), 2008). In the absence of a constitutional sharing of powers and outlining of responsibility for health care, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates the primary health sector to the local government, the secondary health sector to the state government, and the tertiary health sector to the federal government (Federal Ministry of Health (FMOH), 1988). As a result, the three tiers of government are chiefly responsible for three different levels of health care, with

the federal government having little control over both the state and local governments in the discharge of their duties. In addition, the 1988 National Health Policy lacks legal force; unlike the constitution or other legislation, it cannot impose legal obligations. The absence of a constitutional or other legal prescription of health-care responsibilities has resulted in a dysfunctional health-care system in which all three tiers of government have failed to prioritize their health-care duties (HERFON, 2006), and have faced no political or legal repercussions for doing so.

The problem is particularly visible at the primary health-care level, which constitutes the first point of contact with the health-care system, and for which the local governments are chiefly responsible. While the 1988 National Health Policy, in accordance with the Declaration of Alma-Ata, states that the provision of primary health care is indispensable if the health of Nigerians is to be improved, the collapse of this level of care is well acknowledged (HERFON, 2007). Results of other fact findings on some local governments have detailed both the availability of huge financial allocations and the extensive corruption that depletes substantial funds that would have otherwise improved the health sector (Human Right Watch, 2008). The consequences of the separation of governmental responsibility for health care, such as the inability of the federal government to compel the other levels of government—particularly the local level—to fulfil their policy obligations, can be grave. In the Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007 (2004 Health Sector Reform Programme) the Federal Ministry of Health (FMOH) calls for the passing of a National Health Act that would address this gap in the constitution. Along these lines, a bill on the National Health Act was introduced before the National Assembly of Nigeria about three years ago. The Executive Secretary of the Health Reform Foundation of Nigeria, a non-governmental organisation that has pushed for the passage of the bill, identified some of the crucial aspects of the proposed act (Ibrahim, 2008). They include a provision on health-care funding that mandates that the federal government provide 2% of the financing for primary health care, a provision that requires local governments to ensure minimum health care to all citizens, including primary health care, and a provision that obligates state and local governments to contribute specified funds to health care. The upper house of the National Assembly (the Senate) had initially suspended the bill, but subsequently passed it in May 2008 (National Health Bill, 2008). The bill, which must also be passed by the lower house (the House of Representatives) and receive the president's assent before becoming law, does not resolve the uncertainty over each tier's responsibility for health-care provision. While there is hope that ongoing moves for constitutional reform will eventually resolve the issue, enacting such change is often a painstaking and lengthy process. The objective of this study was to determine the perceptions of Local Government Legislators and identified political strategies for maternal mortality reduction in Ibadan, Nigeria.

METHODOLOGY

The Study Area

The study is a community-based descriptive and exploratory one. The scope of the study is delimited to awareness, perceptions and political strategies for reducing maternal mortality.

Study Population

The study population for this study is the Local Government Legislators in all the eleven Local Government Council Areas in Ibadan, Oyo State.

Sampling Procedure

The total population for this study was 110 Legislators in all the LGAs in Ibadan.

Methods for Data Collection

Quantitative (semi-structured questionnaires) method of data collection was adopted for the study. A self administered questionnaire was used to obtain the necessary information from legislators. The questionnaire was developed by the researcher based on literature reviewed with inputs from health promotion specialists in the Faculty of Public Health, University of Ibadan. The questionnaire was used to collect information on the socio-demographic data of the respondents, awareness of maternal mortality, knowledge of maternal mortality, attitudes on maternal mortality, perceptions on maternal mortality and perceived political strategies for reducing maternal mortality reduction. The questionnaire consisted of both open-ended and close-ended questions and was administered by the researcher. The researcher went round all the local governments that were used for the study. The questionnaire was administered in English because all the legislators have at least secondary school certificate which is the lowest qualification to be a legislators in local government.

A 30-point knowledge scale was used to measure the respondents' knowledge. A correct knowledge attracted one point while a wrong knowledge was zero. A score of ≤ 10 points was considered poor while scores between 11-20 points and 21-30 points were considered fair and good knowledge respectively. A 22-point likert scale was used to measure attitudinal disposition of the respondents to maternal mortality. A positive attitude attracted a score of 2 points while the score for a negative attitude was zero. Scores of < 12 and ≥ 12 points were considered negative and positive attitude respectively. Perceptions of MM were also determined using a 22-point perception scale. A positive perception attracted a score of 2 points while the score for a negative perception was zero. Scores of < 12 and ≥ 12 points were considered negative and positive perceptions respectively.

Data Collection Procedure and Analysis

110 questionnaires were self-administered. The leader of the legislators' in each LGA were first contacted by the researcher. During the meeting, the detailed objectives of the study were explained to the leaders to facilitate entry to the Local Government and access to other legislators. Questionnaires were personally distributed by the researcher who went round the 11 LGAs in Ibadan. The data were collected within the period of 43 days. The Statistical Package for Social Sciences (SPSS) was used for the analysis of the data. Descriptive statistics and Chi-Square were used. Frequencies were generated and cross tabulation of some variables.

RESULTS

Demographic Characteristics of the Respondents

The age of the respondents ranged from 20-55 years with mean age of 36.5 ± 7.2 years. Males constituted 90.0% of the surveyed population, 91.8% of all the respondents were married and out of these 24.5% were in polygamous marriage. Seventy-two (65.5%) respondents were Muslims, 41.8% had OND/NCE and 69.1% have spent 3 years as legislators. **(Table 4.1)**

Table 4.1: Socio-demographic characteristics of the respondents

Socio demographic variables	N =110 No	 %
Age (years)		
20-29	18	16.4
30-39	59	53.6
40-49	28	25.5
50-59	5	4.5
Sex:		
Male	99	90.0
Female	11	10.0
Marital status:		
Single	9	8.2
Married	101	91.8
Type of Marriage:		
Monogamous	74	67.3
Polygamous	27	24.5
Religion practice:		
Christianity	38	34.5
Islam	72	65.5
Educational Status:		
Secondary Education	38	34.5
OND/NCE	46	41.8
HND/BSc	26	23.6
Years as a legislator:		
2	23	20.9
3	76	69.1
6	11	10.0

Awareness of maternal mortality

Forty three (39.1%) of the respondents were not aware of high maternal mortality in Nigeria and 60.9% were aware of women who died during pregnancy or childbirth in their constituency. Majority of the respondents (91.8%) were not aware of any existing policies to reduce maternal mortality. All the respondents (100.0%) who were aware of existing policies mentioned MDG as the only policy they aware of. **(Table 4.2)**

Table 4.2: Respondents awareness of Maternal Mortality

Variable	N =110 No	%
Awareness of maternal mortality Yes No	 67 43	 60.9 39.1
Aware of women who died during pregnancy or childbirth Yes No	 67 43	 60.9 39.1
Awareness of the existing policies on maternal mortality reduction Yes No	 9 101	 8.2 91.8
Policies aware MDG	 9	 100

Respondents' Knowledge of Maternal Mortality

The overall mean knowledge score of the respondents' was 16.3±4.4. The mean knowledge scores of respondents with first degree, OND/NCE and SSC were 19.9 ± 3.3, 16.2 ± 4.5 and 14.0 ± 3.1 points respectively ($p<0.05$) and mean knowledge score of male and female were 16.4 ± 4.4 and 15.8 ± 4.2 respectively ($p>0.05$). Twenty (18.2%) of the respondents had a poor knowledge, 65.5% had fair knowledge and the remaining 16.3% had a good knowledge. Majority (87.3%) of the respondents did not know the current maternal mortality ratio and 50.9% did not know that women are at risk of maternal mortality when they have malaria during pregnancy. Many (53.6%) of the respondents did not know that "traditional birth attendants" are not skilled attendant at birth and majority 65.5% did not see women empowerment as one of the ways of preventing maternal mortality. **(Table 4.3)**

Table 4.3 Respondents' knowledge on Maternal Mortality

	Knowledge of maternal mortality	True	False
1.	Direct causes of pregnancy-related death		
	a. Bleeding*	96 (87.3%)	14 (12.7%)
	b. Unsafe abortion*	74 (67.3%)	36 (32.7%)
	c. HIV/AIDS	76 (69.1%)	34 (30.9%)
	d. Headache	31 (28.2%)	79 (71.8%)
	e. Infection*	61 (55.5%)	49 (44.5%)
	f. Rheumatism	66 (60.0%)	44 (40.0%)
	g. Cancer	84 (76.4%)	26 (23.6%)
	h. Hypertension*	81 (73.6%)	29 (26.4%)
2.	One of the Millennium Development Goals calls for the reduction of maternal mortality ratio by three-quarters, by 2015, from the 1990 level.	76 (69.1%)*	34 (30.9%)
3.	The current maternal mortality ratio in Nigeria is 350 deaths per 100,000 live births.	96 (87.3%)	14 (12.7%)*
4.	Most maternal deaths occur during:		
	a. Antenatal period	68 (61.8%)	42 (38.2%)
	b. Labour*	103 (93.6%)	7 (6.4%)
	c. Birth*	76 (69.1%)	34 (30.9%)
	d. Breast feeding	50 (45.5%)	60 (54.5%)
5.	Women are at risk of maternal death when they have malaria during pregnancy.	54 (49.1%)*	56 (50.9%)
6.	A "skilled attendant" at birth may include all of the following:		
	a. A nurse/midwife*	106 (96.4%)	4 (3.6%)
	b. A doctor*	106 (96.4%)	4 (3.6%)
	c. A trained traditional birth attendant	59 (53.6%)	51 (46.4%)
	d. Herbalist	26 (23.6%)	84 (76.4%)
	e. Auxiliary nurse	38 (34.5%)	72 (65.5%)
7.	Prevention of maternal mortality.		
	a. Antenatal care*	106 (96.4%)	4 (3.6%)
	b. Tuberculosis services	75 (68.2%)	35 (31.8%)
	c. Family planning*	82 (74.5%)	28 (25.5%)
	d. Post abortion care*	55 (50.0%)	55 (50.0%)
	e. Cancer screening	87 (79.1%)	23 (20.9%)
	f. HIV counseling and testing	101 (91.8%)	9 (8.2%)
	g. Supervised delivery care*	98 (89.1%)	12 (10.9%)
	h. Breast feeding	49 (44.5%)	61 (55.5%)
	i. Public health education*	75 (68.2%)	35 (31.8%)
	j. Empowerment of women*	38 (34.5%)	72 (65.5%)

*Correct responses

Respondents' Attitude towards Maternal Mortality

The overall mean attitudinal score of the respondents was 14.1 ± 4.5. The mean attitudinal scores of respondents with first degree, OND/NCE and SSC were 17.4 ± 2.8, 13.4 ± 4.6 and 12.8 ± 4.3 points respectively ($p<0.05$) and the mean attitudinal score of male and female were 14.3 ± 4.5 and 13.0 ± 4.6 respectively ($p>0.05$). Many 64.5% of the respondents had a positive attitudinal score while 39 (35.5%) had negative attitude score. Negative attitudes among respondents included *"not supporting a bill to restrict the legal age of marriage because it will cause promiscuity (54.5%)*" and *"a woman using family planning is promiscuous (51.8%)*". **(Table 4.4)**

Table 4.4: Respondents' Attitude towards Maternal Mortality

S/n	Attitudinal Statement	Agree	Disagree	Not Sure
1	If a woman is using family planning I know she is promiscuous	57 51.8%	29 26.4%	24 21.8%
2	I know pregnant women will not go to traditional doctors when there are maternity centres	67 60.9%	12 10.9%	31 28.2%
3	I cannot support more allocation of resources to maternal health, because health workers will not utilize it judiciously.	23 20.9%	60 54.5%	27 24.5%
4	I don't prefer traditional birth attendants to government midwives/nurses for delivery	78 70.9%	8 7.3%	24 21.8%
5	I cannot support a bill to restrict the legal age of marriage because it will cause promiscuity	60 54.5%	37 33.6%	13 11.8%
6	I want pregnant women to pay for antenatal care services for them to appreciate it	31 28.2%	70 63.6%	9 8.2%
7	I cannot support more construction of maternity centres in rural areas because they will not use it.	11 10%	86 78.2%	13 11.8%
8	I want legislators to enforce implementation of existing policies on maternal health.	89 80.9%	10 9.1%	11 10.0%
9	I support legislation on compulsory female child education to reduce maternal mortality	83 75.5%	18 16.4%	9 8.2%
10	I don't want sexuality education to be encouraged for adolescents because they will be promiscuous	49 44.5%	42 38.2%	19 17.3%
11	I want maternal health services to be provided at grassroot level to create more access to the services.	104 94.5%	4 3.6%	2 1.8%

Respondents' Perceptions on Maternal Mortality

Respondents mean perception score was 10.6 ± 4.6 and the mean perception scores of respondents with first degree, OND/NCE and SSC were 13.4 ± 4.0, 9.9 ± 5.2 and 9.4 ± 3.5 respectively ($p<0.05$). Many (54.5%) were of the perception that legislation on compulsory use of antenatal care would not reduce MM. The perception of 78.2% was that abortion should not be legalized inspite of its association with MM when done illegally. The opinion of 60.9% was that legislators should not finance maternal health projects from their constituency allowance. **(Table 4.5)**

Table 4.5: Respondents' perceptions on maternal mortality

	Statement	Agree	Disagree	Not sure
1	Legislation on compulsory use of antenatal care services will not reduce maternal mortality	60 54.5%	38 34.5%	12 10.9%
2	Women should be encouraged to use family planning to reduce maternal mortality	64 58.2%	31 28.2%	15 13.6%
3	Maternal mortality is not a very serious problem that needs immediate attention.	17 15.5%	67 60.9%	26 23.6%
4	Appointment of more doctors by local governments is costly and will not reduce maternal death	42 38.2%	58 52.7%	10 9.1%
5	Legislators' lack of knowledge on the existing policies on maternal health contributes to maternal mortality.	43 39.0%	50 45.5%	17 15.5%
6	Traditional birth attendants are contributing to maternal death by providing substandard care	71 64.5%	21 19.1%	18 16.4%
7	The number of pregnancies a woman had would not affect her health	28 25.5%	50 45.5%	32 29.1%
8	Maternal mortality is not a threat to Nigeria economy	33 30.0%	42 38.2%	35 31.8%
9	Maternal health programmes should be personally financed by the legislators from their constituency allowance.	42 36.2%	67 57.8%	7 6.0%
10	Inadequate monitoring of maternal health programmes by the legislators contributes to maternal mortality.	41 37.3%	62 56.4%	7 6.4%
11	Abortion should be legalized in spite of its association with maternal mortality.	36 32.7%	67 60.9%	7 6.4%

Suggested Political Strategies for Maternal Mortality Reduction

Respondent were asked to proffer strategies for building political will for the reduction of maternal mortality in Nigeria. Various strategies were proffered and these included regular training workshop for political leaders on maternal health (100%), good human relationship between the medical officer of health and political leaders (97.3%), and awareness by international agencies and provision of financial and technical resources (96.4%). **(Table 4.6)**

Table 4.6: Suggested Political Strategies for Maternal Mortality Reduction

	Suggested Strategies	No	%
1	Regular training workshop for political leaders on maternal health	110	100%
2	Involvement of party leaders to give maternal health a priority among party programmes.	97	88.2%
3	Advocacy by community leaders for elected leaders	53	48.2%
4	Involvement of royal fathers to speak with political leaders to give maternal health a priority.	88	80.0%
5	Good human relationship between the medical officer of health and political leaders	107	97.3%
6	Providing credible evidence to show political leaders a problem exist.	96	87.3%
7	Awareness by international agencies and provision of financial and technical resources.	106	96.4%
8	Women pressure group	69	62.7%

N.B: Multiple responses included

DISCUSSION

This study was designed to explore the attitude and perceptions of Local Government Legislators in Ibadan on maternal mortality and strategies for generating political will for its reduction. Political priority for safe motherhood remains nascent because Nigerian government provides minimal financial resources for maternal mortality reduction and with only a few exceptions, state and local governments pay virtually no attention to the issue.

Demographic Characteristics of Respondents

The age range of the respondents was 20-55 years. The minimum age of 20 years reflects the minimum age to be a legislator at the Local Government. The preponderance of male among respondents showed that politics in Nigeria is a male dominated profession. All the respondents have at least Secondary School Certificate. This may be due to the fact that educational qualification is part of the requirements to be a legislator in Nigeria. Some legislators have spent 6 years in office as legislators because they were elected to serve for second term after their first term of 3 years and this is constitutionally allow in Nigeria. Majority of the respondents were Muslims because Ibadan (study area) indigenes were predominately Muslims.

Awareness and Knowledge of Maternal mortality

More than a quarter of the respondents were not aware that maternal mortality is high in Nigeria. This is an indication that there is no adequate sensitization and advocacy for legislators on maternal mortality at the local government. This finding is similar to the study by Lawoyin et al 2007 where respondents were asked if they knew someone who had died a maternal death – while pregnant, at delivery, or within 42 days of termination of pregnancy from a cause related to or aggravated by the pregnancy – 47.8% answered in the affirmative. Many of the legislators were aware of women who died during pregnancy or childbirth in their constituencies, this may be because they were community leaders and were more likely to be informed of every incidence in their communities. The respondents showed a fair knowledge of maternal mortality. A large proportion of the respondents did not know the current maternal mortality ratio in Nigeria. This corresponds to the study by Okonofua et al (2009) which revealed that only 2 out of 49 policymakers interviewed correctly reported the current maternal mortality statistics. Bleeding was identified by the respondents as the major cause of maternal mortality. This finding is also consistent with those of Okonofua et al (2009) study where bleeding during childbirth (obstetric hemorrhage) was the complication most commonly cited by the respondents as a medical cause of maternal mortality. Many of the respondents believed that HIV/AIDS is one of the direct causes of maternal mortality. This is a clue that these legislators did not also have adequate knowledge of HIV/AIDS. Half of the respondents' believed that women are not at risk when they have malaria during pregnancy. This showed that some people still do not see malaria as a serious health problem that needs immediate attention especially for the pregnant women. More than half of the respondents see TBAs as skilled attendants at birth. According to the respondents in a study by Lawoyin et al (2007), the more important reasons for using unskilled workers were the high cost and lack of access to health facility care.

Many of the legislators did not see post abortion care as one of the ways to prevent maternal death. This finding is similar to the study by Shamshiri-Milani et al, 2003 in Iran where a strong disagreement was observed towards abortion among policymakers studied.

Attitude towards maternal mortality

The participants overall attitude was positive. A large number of the respondents demonstrated their agreement with more allocation of resources to maternal health. Federal budgetary resource for maternal mortality reduction in Nigeria is a dearth. It was in 2004 for the first time that Federal Government provided a line item allocation for reproductive health, a portion of which was directed towards safe motherhood. Many participants had negative attitude towards sexuality education for adolescents because of the belief that they will be promiscuous. The National Council on Education and Health had approved a National Curriculum for Sexuality Education in Primary and Secondary Educational Institutions in Nigeria, but a sizeable number of states, especially the predominately Muslim states in Northern Nigeria, have failed to adopt the curriculum because of religious and moral considerations. Many of the legislators want maternal health services to be provided at grass root level to create more access to the services. They suggested that an improved system would increase access to appropriate services, including family planning and post abortion care. This finding is similar to the study by Okonofua et al (2009) where many policymakers cited improving healthcare system as essential for maternal mortality reduction. A large proportion of legislators supported the idea of free medical services for pregnant women; this suggests that there is a broad support for the recent decision of the Federal Government and some State Governments in Nigeria to offer free medical services to pregnant women to improve maternal survival. This is also in accordance with the findings of Okonofua et al (2009) which revealed that a large proportion of policymakers supported the idea of free medical services for women, including post-abortion care. When asked if they support the use of family planning as one of the ways to reduce maternal death, a majority disagreed; they agreed that women who are using family planning are promiscuous. This belief will compromise preventive measure because access to family planning or contraceptives methods is an important strategy in reducing maternal mortality. However, the Nigerian government has failed to take steps to ensure access to these methods; many Nigerian women therefore do not benefit from this crucial option. The consequences of this low usage of family planning methods include a high occurrence of unplanned pregnancies which therefore increase the likelihood of exposure to unsafe abortion. Many of the respondents agreed that legislators should enforce the implementation of existing policies on maternal health. Several national and regional laws and policies obligate Nigeria to provide health services in a manner that is adequate, affordable and accessible. The 2001 National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians calls for the empowerment health care providers to provide comprehensive (including referral), client-oriented reproductive health services that are of quality, equitably accessible, affordable and appropriate to the needs of individual men and women, families and communities, especially underserved groups. The policy specifically calls for the removal of all forms of barriers that limit access to comprehensive, integrated and qualitative reproductive health care. This policy is in line with men's opinions on what should be done to address maternal mortality. In a study by Lawoyin et al (2007), men suggested to Government to provide specialized (obstetric) antenatal care and making it close to the masses. They also suggested that Government should help the poor, equip hospitals, train more doctors and increase the number of clinic and health facilities, build community awareness about maternal deaths and the need to get care at facilities provided free care and subsidized treatment and encourage family planning.

Perceptions on maternal mortality

The participants overall perception was negative. Many of the respondents were of the perception that the number of pregnancies a woman had would not affect her health. This is an indication that the respondents may not support their wives for family planning. In a study carried out in the Republic of Benin, a neighboring West African country, none of the men interviewed in a reproductive health survey thought that the number of pregnancies a woman had would affect her health (Lawoyin et al., 2007). More than half of the respondents disagreed with the notion that legislators should personally financed maternal health programmes from their constituency allowance. This could be one of the contributors to inadequate resources to maternal health because legislators are also constitutionally charged with the responsibility of implementing constituency project from their constituency allowance. One of the challenges facing the local government is the provision of an adequate number of skilled health-care providers to handle the huge influx of women that come for services and some of the respondents were of the opinion that appointment of more doctors by local government is costly and will not reduce maternal death. In all the local governments in the study area, there is only one medical officer for health in each local government and only one medical officer cannot serve the whole local government. Majority of the respondents disagreed that abortion should be legalized in spite of its association with maternal mortality. This corresponds with the findings by Okonofua et al (2009) where many of the policymakers thought that liberalization would increase the number of abortions. They opined that abortion should not be legal under any circumstances and a significant proportion suggested that the solution to unsafe abortion is not to legalize the procedure but to provide sexuality education. Unsafe abortions are a major cause of maternal death in Nigeria. Both the human rights committee and the CEDAW committee have expressed concern and issued recommendations about it in regard to Nigeria. It is important to note that the Maputo Protocol provided in Article 14 (2) (c) that a state's obligation to guarantee the right to health includes protecting 'the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incents and where the continued pregnancy endangers the mental and physical health of the mothers' (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003).

Level of education and knowledge of maternal mortality

The result of the study revealed that the educational level of respondents is related to the knowledge and perception of maternal mortality. The higher the level of education of the legislators, the higher the knowledge and better perception of maternal mortality. Respondents with HND/first degree have higher knowledge of maternal mortality than their counterparts who have OND/NCE and Secondary School Certificate. Previous study also supports this finding (Lawoyin etal, 2007)

Implications of the findings for reproductive health promotion and education

The findings of this study have several implications for planning, development and implementation of sensitization and advocacy programme for legislators in Ibadan and Nigeria as a whole. It is essential to provide legislators with current evidence based information on maternal mortality to increase their knowledge of the situation and to encourage them to develop relevant, scientifically appropriate solutions to the problem. Message should focus on providing accurate statistics as well as graphic narratives of the illustrative cases, and on explaining how the problem needs to be tackled, ideally using the experiences of other countries.

Unfortunately, no formal forum exists for legislators in Nigeria to discuss matters related to women's health. The parliament of Ghana has a caucus that meets regularly to share information on reproductive health issues (Ghana Statiscal Services and Macro International, 1999). This has been responsible for promoting programmes and policies designed to improve reproductive health in Ghana. Although the Nigerian National Assembly has standing committee on health and women's affairs, this committee has done little to address women's health needs. Indeed, the Health Committee of the Nigerian Senate has repeatedly blocked legislation on reproductive health, claiming that such legislation was a ploy to legalized abortion (Sen. Daisy Danjuma, 2005). Thus, an avenue for regular sharing appropriate information with policymakers on maternal health, especially issues related to maternal mortality is needed.

Conclusion

This study found that many of the legislators were not aware that maternal mortality is high in Nigeria and negative perceptions of maternal mortality existed among them. Inadequate knowledge of causes and prevention of maternal mortality were also recorded in this study. However legislators with higher educational qualifications have positive perceptions of maternal mortality. Advocacy and the integration of their suggestions into control efforts have potential for ameliorating the problem.

REFERENCES

African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria. 2001. Apr. 24-27, para. 26,O.A.U. Doc. OAU/SPS/ABUJA/3

African Union Conference of Ministers of Health. 2006. Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010, Sp/MIN/CAMH/5(1)

Beijing Declaration and the Platform for Action. 1996. Fourth World Conference on Women, Beijing, China, Sept. 4-5, 1995, U.N. Doc. A/CONF.177/20.

CEDAW. 2008. Consideration of reports, Nigeria 81.

CEDAW. 2006. Consideration of reports, Nigeria 82.

Dare, F.O., Bako, A.U., Ezechi, O.C. 1998. Puerperal sepsis: a preventable post-partum complication. *Trop Doct.* 28(2):92-5. [PubMed]

Declaration of Alma-Ata, International Conference on Primary Health Care. 1978. para. V, Alma-Ata, USSR, Sept. 6-12.

Department of Economic and Social Affairs, Population Division, United Nations. 2007. *World Population Prospects,* 2006 Revision, New York: United Nations.

Eslami, S.H. 2005. Ethical approaches to abortion; a case study. *Journal of Reproductive Infertily.* 6(4):321-42. Persian.

Fatusi, A.O. and Ijadunola, K.T. 2003. National Study on Essential Obstetric Care Facilities in Nigeria (Federal Ministry of Health [Nigeria] and UNFPA) at vii, 11

Federal Government of Nigeria. 2004. National Policy on Population for Sustainable Development 20.

Federal Ministry of Health (Nigeria) and World Health Organization (WHO). 2005. Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Nigeria.

Federal Ministry of Health (Nigeria). 2005. Health Sector Reform Programme 2004

Federal Ministry of Health (Nigeria). 2007. Integrated Maternal, Newborn and Child Health Strategy 2.

Federal Ministry of Health (Nigeria). 1988. National Health Policy and Strategy to Achieve Health for All Nigerians.

Federal Ministry of Health (Nigeria). 2006. National HIV/ AIDS and Reproductive Health Survey 2005 at 101-103

Federal Ministry of Health (Nigeria). 2007. National Policy on the Health & Development of Adolescents & Young People in Nigeria.

Federal Ministry of Health (Nigeria). 2004. Revised National Health Policy, at 9-10, sec. 4.6

Federal Ministry of Women Affairs and Social Development (Nigeria). 2006. National Gender Policy.

Federal Republic of Nigeria Official Gazette. 2007, 94(4), S.I. No. 5.

Federal Republic of Nigeria. 2006. Legal notice on publication of the 2006 Census Report,

Ghana Statistical Service and Macro International. 1999. Ghana Demographic and Health Survey 1998, Calverton, MD, USA: GSS and Macro International.

Guttmacher Institute. 2006. Facts on Unwanted Pregnancy and Induced Abortion in Nigeria

Health for All Nigerians. 1988. 12-13, 53, sec. 5.5(a)-(c), Annex II [hereinafter Nigeria, Health Reform Foundation of Nigeria (HERFON), Nigerian Health Review 2006 at 105 (2006)

Henshaw, S. K. et al. 2008. Severity and cost of unsafe abortion complications treated in Nigerian hospitals, *International Family Planning Perspectives,* 34(1):40–50.

Health Reform Foundation of Nigeria (HERFON). 2006. Nigerian Health Review 110.

Health Reform Foundation of Nigeria (HERFON). 2006. Nigerian Health Review 119.

Health Reform Foundation of Nigeria (HERFON). 2006. Nigerian Health Review at 33-34

Hord, C. et al., Reproductive health in Romania: reversing the Ceausescu legacy, Studies in Family Planning, 1991, 22(4):231-240.

Hourieh Shamshiri-Milani, Abolghasem Pourreza and Feizollah Akbari. 2010. 'Knowledge and Attitudes of a Number of Iranian Policy-makers towards Abortion' *Journal Reproductive Infertily,* Volume 11, Issue 3, Number 44.

Human Rights Committee. 2000. General Comment No. 28: Equality of rights between men and women, para.10, U.N. Doc. CCPR/C/21/Rev/1/Add/10) [hereinafter HRC, General Comment No. 28].

Human Rights Watch. 2007. Chop Fine: The Human Rights Impact of Local Government Corruption and Mismanagement in Rivers State, Nigeria, Vol. 19, No. 2(A), at 42-48.

Hyacinth, I. and William, F. 2006. The Distributional Impact of Healthcare Financing in Nigeria: A Case Study of Enugu State 3 (Poverty and Economic Policy, PMMA Working Paper No. 17)

Ujah, I.A.O. et al., *Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeenyear Review*, African Journal of Reproductive Health, Vol. 9, No. 3*,* at abstract (2005).

Ikechebelu, J.I. and Okoli, C.C. 2003. Morbidity and mortality following induced abortion in Nnewi, Nigeria. *Trop Doct.* ;33(3):170-2. [PubMed]

International Planned Parenthood Federation (IPPF). 2004. Medical and service delivery guidelines for sexual and reproductive health services. 3rd ed. London: IPPF; p. 281.

Jeremy Shiffman. 2007. Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries. *American Journal of Public Health,* Vol. 97, No. 5, at 798

Kuliya-Gwarzo and Kwaru, A.H. Pattern of Blood Donation in Aminu Kano Teaching Hospital, *Journal of Medicine and Rehabilitation,* Vol. 1, No.1, at 35

Lithur, N. O. 2004. Destigmatising abortion: expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health,* 8 (1):70-74.

Maputo Declaration. 2004. Together Shaping Our Future, 4th Summit of ACP Heads of State and Government, Maputo, Mozambique, June 23-24, para. 30, O.A.U. Doc. ACP/28/010/04

McIntyre J. 2003. Mothers infected with HIV. *Br Medical Bulletin*. 67:127-35. Review. [PubMed]

Mehrgan, A. H. 2005. Abortion and human rights in the outlook of international laws. *Journal of Reproductive Infertility.* 6(4):410-40. Persian.

National Health Policy and Strategy to Achieve Health for All Nigerians. 1988

National Population Commission (NPC) (Nigeria) and ORC Macro. 2004. Nigeria Demographic and Health Survey. at 67, tbl.5.4

National Population Commission (NPC) (Nigeria) and ORC Macro. 2004. Nigeria Demographic and Health Survey 2003 at 3.

National Population Commission (NPC) (Nigeria) and ORC Macro. 2004. Nigeria Demographic and Health Survey 2003, at xxiii.

Federal Ministry of Health (Nigeria). 2006. National HIV/AIDS and Reproductive Health Survey 2005 at 117, tbl.11.6.

Nigeria National Health Policy and Strategy to Achieve Health for All Nigerians. 1988. 12-13, sec. 5.5(a)-(c).

Nigeria National Health Policy and Strategy to Achieve Health for All Nigerians.1988. at 7, sec. 3.3.

Obinna, O. 2005. Lower costs do not mean better health care in Nigeria. Id 21 health highlights, No.16, at 2

Okolocha, C., Chiwuzie, J., Braimoh, S., Unigbe, J. and Olumeko P. 1998. Socio-cultural factors in maternal morbidity and mortality: a study of a semi-urban community in southern Nigeria. *Journal of Epidemiology and Community Health.* 52:293-7

Okonofua, F. E., Hammed, A., Nzeribe, E., Saidu, B., Abass, T., and Adeboye, G. 2009. Perceptions of policy-makers in Nigeria toward unsafe abortion and maternal mortality. *International Perspect Sex Reproductive Health.* 35(4):194-202

Onwuka, N. 2008. Abortion Law Blamed for High Maternal Death, This Day, May 28, p.23

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. 2003. Art. 14(2)(c), adopted July 11, 2nd African Union Assembly, Maputo, Mozambique [hereinafter Maputo Protocol].

Prual, A., Bouvier-Colle, M. H., de Bernis, L., and Breart, G. 2000. Severe maternal morbidity from direct obstetric causes in West Africa: incidence and case fatality rates. *Bulletin of World Health Organization.* 78(5):593-602.

Sen. Daisy Danjuma. 2005. 'A bill to establish a national institute of reproductive health, presented to the Senate of the Federal Republic of Nigeria. (Oct. 15,).

Senate (Nigeria). 2008. National Health Bill (SB.50)

Shamshiri, M.H. 2003. Health, it's dimensions and status of abortion related to health]. In: Comprehensive Study on Abortion in Iran; 2003 Feb 26-27; Kermanshah. Tehran: Avicenna Research Institute; p. 104. Persian.

Stanley, K. Henshaw et al. 2008. Severity and Cost of Unsafe Abortion Complications Treated in Nigerian Hospitals, *International Family Planning Perspectives*, Vol. 34, No. 1, at 40

Stephenson, P. et al. 1992. Commentary: the public health consequences of restricted induced abortion-lessons from Romania, *American Journal of Public Health,* 82 (10): 1328-1331.

Stevens, M. 2000. Abortion reform in South Africa, Initiatives in Reproductive Health Policy. 3(2):4-6.

Lawoyin, T. O., Olusheyi, O. C., Lawoyin and Adewole, D. A. 2007. 'Men's Perception of Maternal Mortality in Nigeria' *Journal of Public Health Policy* 28, 299–318.

The ENHANSE Project. 2005. Reproductive Health in Nigeria: Situation, Response & Prospects 24.

UNFPA and UNIFEM. 2006. Gender Responsive Budgeting 73.

UNFPA and UNIFEM. 2006. Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack 74 [hereinafter UNFPA and UNIFEM, Gender Responsive Budgeting (2006)]

United Nations Children's Fund (UNICEF). 2006. At a Glance: Nigeria

United Nations Children's Fund (UNICEF). 2007. The Nigerian Situation

United Nations Division for the Advancement of Women. 2000. The Feminization of Poverty (Fact Sheet No. 1)

United Nations General Assembly. 2005. World Summit Outcome, 60th Sess., para. 22(a), U.N. Doc. A/RES/60/1

United Nations Population Fund (UNFPA). 2008. Maternal Morbidity.

United Nations Population Fund (UNFPA). 2008. Skilled Attendance at Birth

United Nations Population Fund (UNFPA). 2005. State of World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals 36

Wager, G.P., Martin, D.H., Koutsky, L., Eschenbach, D. A, Daling, J. R., Chiang, W. T., Alexander E.R. and Holmes KK. 1980. Puerperal infectious morbidity: relationship to route of delivery and to antepartum Chlamydia trachomatis infection. *American Journal of Obstetrics and Gynecology.* Dec 1;138(7 Pt 2):1028-33. [PubMed]

Whittaker, A. 2002. Reproducing inequalities: abortion policy and practice in Thailand. Women Health. 35(4):101-19.

World Health Organization et al., Maternal Mortality in 2005 at 16 (2007).

World Health Organization et al., Maternal Mortality in 2005 at 25 (2007).

World Health Organization. 1992. International Classification of Diseases and related Health Problems-10th Revision. Geneva, Switzerland:

World Health Organization. 2004. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000, 4th ed., Geneva: WHO

World Health Organization. 2006. Regional Committee for Africa Resolution, Health Financing: A Strategy for the African Region, AFR/RC56/R5, para. 2(c)

World Health Organization. 2008. Causes of maternal death.

World H ealth Organization. 2008. Why Do So Many Women Still Die in Pregnancy or Child Birth? Apr. 30).