proportion of patients surviving into childbearing age. However, SCD in pregnancy is associated with increased adverse maternal and fetal outcomes. It is a high-risk condition associated with higher rates of adverse maternal and fetal complications in addition to SCD-specific complications. Studies in developed countries such as the US have not shown SCD to be associated with increased risk of maternal death. In low and middle-income countries, however, there is a 22-fold risk of death among pregnant women with SCD compared to those without SCD, with a maternal death rate between 7-12%. At Korle-Bu Teaching Hospital (KBTH) in Accra, Ghana, 11,000-12,000 deliveries are performed per year, and 2% of these women are affected by SCD. In spite of the relatively small numbers of annual deliveries by women with SCD, they contribute a disproportionate burden of maternal mortality. In 2014, maternal death from SCD contributed to 14% of all maternal mortality and ranked as the third leading cause of death.

It is unclear whether the immediate cause of death in pregnant women with SCD significantly differs from those without SCD. Knowledge of the immediate causes of death and the factors related to death will provide useful information for the development of interventions to reduce the excess maternal death in women with SCD.

Methods: In this retrospective descriptive study, we compared maternal mortality in pregnant women with SCD to those without SCD. Hospital charts and autopsy reports of 18 SCD-related maternal deaths were reviewed and compared with those of 55 women without SCD. Detailed chart review was performed for all 73 patients. Demographic data, obstetric history, admission treatment, intrapartum complications, delivery outcome and clinical and post-mortem causes of death were extracted, and simple descriptive analysis was performed to compare the causes of death between the two groups.

Findings: n/a.

Interpretation: n/a.

Source of Funding: None.

Abstract #: *2.009_WOM*

Partner Notification and Treatment for Sexually Transmitted Infections among Pregnant Women in Gaborone, Botswana

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Background: *Chlamydia trachomatis (CT), Neisseria gonorrhoeae(NG),* and *Trichomonas vaginalis (TV)* are sexually transmitted infections (STIs) associated with adverse birth outcomes. Untreated partners contribute to high rates of STI re-infection, thus partner notification and treatment remain important components of STI care and control.

Methods: A prospective cohort study was conducted among 300 pregnant women presenting to the antenatal clinic at Princess Marina Hospital in Gaborone, Botswana and enrolled in an STI screening study. Following informed consent, and sample collection for CT/NG/TV testing, participants were asked if they were willing to disclose their STI result to their partner(s) and willing to deliver medications to their partner(s). Those who tested positive were asked at a follow-up appointment if they notified their partners.

Findings: Among the 300 participants, 294 (98%) said they would be willing to tell their partner(s) about their test results if they test positive, and 284 (95%) said they would be willing to give their partner(s) medication if the option was available. Of those who tested positive and returned for a test of cure, 27 of 32 (84%) reported that they told their partner about the results, and 19 of 32 (59%) reported that their partner received treatment. A Fisher's exact test comparing those who told their partners about their test results and those who reported their partner received treatment showed that the difference was statistically significant ($p = 0.019$).

Interpretation: Almost all pregnant women reported willingness to tell their partner their test results and give their partner medications. At test of cure, most women reported informing their partner, although actual treatment receipt was lower. Our findings suggest that pregnant women are willing to utilize partner based partner notification, but actual partner treatment might be lower than intended.

Source of Funding: UCLA Center for World Health DGSOM Short Term Training Program.

Abstract #: *2.010_WOM*

Gender Differences in Households' Resource Alllocation and Decision to Seek Healthcare in South-Eastern Nigeria: Results from a Mixed Methods Study

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Background: In many low and middle income countries (LMICs), economic costs of seeking healthcare is still the predominant barrier to healthcare utilisation. This barrier is exacerbated when gender dynamics are considered with the most vulnerable being females within these poor household. Studies have found existing gaps in literature regarding women's autonomy and health care utilization. This include gaps in the areas of healthcare that have been measured, the influence of sex roles and social support, and the use of qualitative studies to provide context and nuance. Gender constructs and norms are still prevalent in many LMICs and restrict women and girls' ability to exercise agency in contributing to household decision-making and access to healthcare.

Methods: To examine the gender differences in household custody of financial resources, decision-making, and type of healthcare utilised, I used a mixed method approach of cross-sectional household surveys and focus-group discussions (FGDs). A total of 411 households were interviewed (111 in urban and 300 in rural communities). I conducted six single-sex FGDs in 3 communities (1 urban, 2 rural) among a sub-sample of participants in the household survey. For the quantitative data, I preformed univariate, bivariate, and logistic regression analyses with a 95% confidence interval. For the

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qualitative data, I performed thematic analysis where broad themes relevant to the research objective were extracted.

Findings: More households in male-headed households (MMHs) reported utilising facility-based healthcare compared to household with female heads (FHHs). Households with a male sick member were nineteen times more likely to utilise facility-based healthcare relative to sick female household members (19.50, 95% CI 9.62-39.52). There were more reports of sole custody of household resources in MHHs against FHHs (88% vs 61%). Joint decision-making on healthcare expenditure was higher in FHHs (28% vs 19%). Qualitatively, women spoke of seeking permission from male household head before any expenditure while male heads spoke of concealing household financial resources from their spouse.

Interpretation: This study confirms the role of gender in household resources allocation and healthcare utilisation and calls for efforts to redress these prevalent inequities. I recommend that interventions that seek to improve women's agency and autonomy should incorporate strategies to reduce household level gender differences and inequalities.

Source of Funding: None.

Abstract #: *2.012_WOM*

Determinants of Contraception among Women with a Previous Ceasarean Section in the Kumasi Metropolis, Ghana

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Background: A previous Caesarean section (CS) confers high risk on the index pregnancy. Ensuring optimal inter-pregnancy intervals and the reduction of unintended pregnancies among this sub-population of high risk pregnancies is important for maternal health and survival. Contraception is encouraged especially after CS in order to reduce the risk of a short inter-pregnancy interval. The determinants of contraception among women has been widely studied but there are few studies that have looked at the predictors of contraception among this high risk subpopulation - women with a previous CS.

Methods: A survey of 484 women with at least one previous CS was conducted in the top-5 hospitals in terms of deliveries in Kumasi, Ghana. A questionnaire with questions that sought to measure the predictors of contraception, exposure to contraceptive counselling during the continuum of care, and the quality of family planning couselling was used. Data were subjected to various levels of logistic regression analyses.

Findings: After adjusting for covariates, partners' occupation, previous contraception, exposure to counselling, and the number of previous CS were significant predictors of contrceptive uptake. When compared with women whose partners were professionals, women whose partners were artisans were signfcantly less likely to take up contraception after CS. Women with a history of previous uptake had a signficantly higher odds of uptake post-CS compared with women without previous uptake. Women who received some form of counselling were signficantly more likely to take up contraception. At each point of care (from antenatal to postnatal) nearly 30% of respondents had some form of counselling; two-thirds did not receive any counselling along the continuum of care and only 11% received cousnelling at all points of care.When compared with women who had an inter-pregnancy interval of less than 24 months post-CS, women with an interval greater than 24 months were signficantly more likely to have used contraceptives after CS.

Interpretation: Maternal and child healthcare staff should be trained to improve the quality of their counselling to encourage women to take up contraception post-CS. A context-based adaptation of the Balanced Counselling Startegy into family planning services maybe helpful.

Source of Funding: Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health.

Abstract #: *2.013_WOM*

Improving Emergency Obstetric and Neonatal Care (EmONC) Practices through Retrospective Analysis of Intrapartum Stillbirth Data at the Fort Portal Regional Referral Hospital, Southwesten Uganda

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Background: Through support from the Saving Mothers Giving Life Initiative, Fort Portal Regional Referral Hospital (FPRRH) has used the BABIES (Birthweight Age-at-death Boxes for Intervention and Evaluating System) matrix to track progress in perinatal care since 2013. The BABIES matrix is an epidemiological tool which uses birthweight and time of death to define newborn health problems, assess the performance of a health system, select interventions, and then monitor and evaluate these interventions. From 2013 to 2015, the birthweight-specific mortality rates of normal birthweight babies (2,500g+) increased from 12.1 to 19.2 intrapartum stillbirths per 1000 total births, indicating a gap in care during labor.

Methods: To identify these potential gaps in care during labor, we conducted an in-depth retrospective analysis of patient case sheet data from FPRRH. Inclusion criteria included intrapartum stillbirths of normal birthweight babies during 2015.

Findings: In 2015, 118 cases were identified but only 40.7% of the patient case sheets were found within the hospital's records and few were entirely complete. From the recovered patient case sheet data, 56% of the studied intrapartum stillbirths were accompanied by record of referral into the hospital. 14.6% were associated with cord prolapse, 14.6% with a ruptured uterus, 22.9% with an abnormal lie, and 16.7% associated with obstructed labor.

Interpretation: The lack of detailed record keeping and organization resulted in a reduction of data for analysis. In addition to