Knowledge, Attitude and Practice of Birth Preparedness and Complication Readiness Amongst Pregnant Women in Eti-osa Lga, Lagos

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Abstract Background: Maternal mortality still remains a major challenge in developing countries. In sub-Saharan Africa, one out of every sixteen women dies of pregnancy-related causes. Birth preparedness and complication readiness is the process of planning for normal birth and anticipating the actions needed in case of an emergency. This is a study to assess the knowledge, attitude and practice of birth preparedness and complication readiness. Methodology: This is a descriptive cross-sectional study to assess the knowledge, attitude and practice of birth preparedness and complication readiness among antenatal care attendees in Eti-Osa local government area of Lagos State. A systematic sampling technique was used to select the respondents. The data used for this study were collected from pregnant women attending antenatal care in Six Primary Health Care centers in Eti-Osa local government area of Lagos State, using a structured pretested English language, interviewer-administered questionnaire. Results: The mean age of the respondents was 28.9 years, with standard deviation of 5.3 years. The proportion of respondents who have been prepared for birth and for its possible complication was 124 (33.4%). A higher proportion of the married women 212 (72.6%) were better prepared for birth and ready for its possible complication. 120 (83.9%) of pregnant women who had attended tertiary education were prepared for birth and for its complications ($p=0.001$). Conclusion: Few pregnant women had made adequate arrangements in anticipation for a safe normal delivery.

Keywords Birth Prepared Complication Ready, Pregnant Women, Antenatal Care, and Primary Health Care

unborn offspring inside her body, from fertilization to birth. Child birth is the processes of having a baby emerge from the womb. Under normal conditions, pregnancy and child birth are not a disease but a physiological process. There is, therefore, no need for any woman to die as a result of pregnancy or child birth. In developing countries of the world, many women face increased risk of morbidity from pregnancy and child birth [1].

Birth preparedness and complication readiness is the process of planning for normal birth and anticipating the actions needed in case of an emergency [2]. Responsibility for birth preparedness is shared among all the stakeholders of safe motherhood: policymakers, facility managers, providers, communities, families, and women, because a coordinated effort is needed to reduce the delays that contribute to maternal and newborn deaths [2]. Birth preparedness covers all aspects of pregnancy and child birth, including preconception care, antenatal care, and medical problems during pregnancy, disorder that might affect the unborn baby, complications arising during pregnancy, the induction of labor, and the care of the mother and child during childbirth [3]. It aids the pregnant woman in the identification of the risk factors that can lead to complications in pregnancy. These risk factors include: hemorrhage, infection, anemia, smoking, hypertension, poor diet, diabetes, etc. It involves adequate and proper planning for the physical, psychological, financial and emotional aspect that can affect the outcome of pregnancy. Despite the great potential of birth preparedness for reducing the maternal and newborn deaths, the success of this strategy is not well known in most of Sub-Sahara Africa [4].

Statement of the Problem

Maternal mortality remains a major public health challenge in the developing countries, and the little progress made towards the achievement of millennium

1. Introduction

Pregnancy is the physical condition of a woman carrying

development goals, especially the goal of achieving three-quarter reduction in maternal mortality ratio by 2015 can essentially be attributed to the little achievements of low and middle income countries in this regard. A major strategy that can reduce the maternal mortality ratio is to making a birth plan or birth preparedness and complication awareness [4].

Lack of advance planning for accessing the services of a skilled birth attendant for normal births, and inadequate preparation for rapid intervention in the event of obstetric complications, are well documented factors contributing to delay in receiving skilled obstetric care. Globally, about 289,000 mothers die each year because of problems related to pregnancy and child birth. About 95% of these cases occur in developing countries, Sub-Saharan Africa (56%) and Southern Asia (29%) accounts for 85% of the global burden of maternal death [5]. With this disparity, the maternal mortality rate in developing countries is more than 15 times higher than in the developing regions [5]. While almost all developed countries have achieved the desired three-quarter reduction of maternal mortality by 2015, many of developing countries are still struggling. However, most of the resource limited countries in Sub-Saharan Africa have shown the slowest progress, with an average annual rate of decline of 2.6 % [6].

Nigeria is one of the Sub-Saharan African countries with high maternal mortality ratio (MMR). The MMR in the Nigerian Demographic and Health Survey (NDHS) in 2015 was 560 per 100,000 live births, which had shown a slightly significant decline compared to 740 and 950 per 100,000 live births in NDHS surveys in 2005 and 2000, respectively [7]. As a result, improving maternal health status so as to achieve the intended target is among the top priority areas of the country.

Justification and Rationale of the Study

Maternal mortality is one of the key indices of the health state and quality of health care of a society. The public health burden of maternal mortality is huge, hence improving maternal health has received recognition at the global level as evidenced by its inclusion in millennium developmental goals. Owing to pregnancy-related complications, more than half a million women die each year worldwide [8]. Ninety-nine percent of maternal deaths occur in the developing world, and most of these deaths are preventable [9]. The chances of dying from maternal complications are 1 in 16 in developing countries, compared to 1 in 2800 in developed countries [10]. Each year, more than 50 million women give birth at home and without the help of a trained professional [11]. For every woman who dies during childbirth, another 30 women suffer injury, infection or complications [9].

Birth preparedness and complication readiness is a strategy to promote utilization of skilled maternal and neonatal care timely, based on the theory that preparing for childbirth and being ready for complications reduces

delays in obtaining this care [12]. In a skilled care approach, birth preparedness includes identifying a skilled provider and making the necessary plans to receive skilled care for all births [13]. Complication readiness (emergency funds, transport, blood donor and designated decision maker) receive greater emphasis in emergency obstetric care programs.

Birth preparedness and complication readiness has been globally endorsed as an essential component of safe motherhood programs to reduce delays for care [13].

The research seeks to assess the knowledge, attitude and practice of birth preparedness and complication readiness and also factors that are associated with it. The findings from this study will provide information for informed public health actions targeted towards reduction of maternal mortality. It will also contribute to research in area of improvement of maternal health.

Study Objective

The general objective of this present research is to assess the knowledge, attitude and practice of Birth preparedness and complication readiness among antenatal care attendees in Eti-Osa Local Government Area of Lagos State.

The study has the following specific objectives:

1. To assess the Knowledge of Birth preparedness and complication readiness among antenatal care attendees in Eti-Osa Local Government Area of Lagos State.
2. To determine the attitude of pregnant women attending antenatal care in Eti-osa LGA to birth preparedness and complication readiness.
3. To identify the factors associated with birth preparedness and complication readiness among antenatal care attendees in Eti-Osa Local Government Area of Lagos State.

2. Materials and Method

This is a cross-sectional descriptive study, aimed at assessing the knowledge, attitude and practice of birth preparedness and complication readiness among antenatal clinic attendees in Eti-Osa Local Government Area of Lagos State.

The study was conducted amongst pregnant women attending primary health care in Eti-Osa local government area.

Only pregnant women, permanent residents, who attend ante-natal care in primary health care in Eti-Osal local government area.

Those who failed to give consent and were temporary residents in the study area were excluded. These criteria were applied to ensure a uniform selection of study participants.

The minimum sample size was determined [14] by using the Cochran formula for a population greater than 10,000.

$$n = Z^2 pq/d^2 \quad (1)$$

Where n= Minimum sample size required

Z= level of statistical significance at 95% confidence level i.e. 1.96

p= Awareness of birth preparedness and complication readiness (A study carried out in Ethiopia)

d= Acceptable margin of sampling error 0.05

q=1-p

Therefore, by considering:

Z=1.96

P=70.6% to decimal =0.706

q=1-0.706

The minimum number of patients included in this study resulted as

$$\begin{aligned} &= 0.294 \\ &= \frac{1.96 \times 0.706 \times 0.294}{0.05^2} \\ &= \frac{3.841 \times 0.706 \times 0.294}{0.0025} \\ &= 318.95 \end{aligned}$$

If 10% of the total number of respondents gave a non-valid response, then the minimum number of patients becomes:

$$\begin{aligned} n(100\% - 10\%) \\ n &= \frac{319}{0.90} \\ &= 354.4 \\ &= 360 \text{ to nearest whole number} \end{aligned}$$

Finally, the number of subjects of in this study was of 360 pregnant women.

Sampling Technique

A total of 360 pregnant women who attended antenatal clinic in the PHC were recruited for the study. A systematic sampling technique was used for selection of the subjects based on the monthly clinic attendance and using the antenatal care register obtained from the health care workers in each primary health care center. With a sampling interval of 2 (i.e., 120/60), 1 in every 2 antenatal care clients was selected until the required sample size was met. The starting point for selection was determined by picking a random number from the clinic register, between 1 and 2. Subsequent respondents were identified by adding the sampling interval to the preceding respondents' serial number on the ANC register until the required sample size was met.

After selecting a random starting point, the respondents in each primary health care center was selected until the desired sample size in each PHC was reached. The respondents were selected proportionally to client caseload per level of facility.

Data Collection Tool

The data in this study were collected using a structured pretested English language interviewer-administered questionnaire. A standard tool adapted from the safe motherhood questionnaire developed by maternal and neonatal health program of John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) the affiliate of John Hopkins University [15]. The questionnaire was divided into four sections, namely: socio-demographics, knowledge, attitude and practice of birth preparedness and complication readiness among antenatal care Prior to the actual study, the questionnaire was tested among pregnant women in Isolo LGA. Feedback from the pre-test was used to make appropriate corrections in the questionnaire

Data Collection and Analysis

On the day of data collection, each pregnant woman in the selected PHC center was first informed of the reason and nature of the study. They were assured that information provided will be treated with strict confidentiality. All completed questionnaire was collected and appropriately coded immediately after. Prior to data analysis, the information was collected using Microsoft excel office software. It was imported into Statistical Package for Social Sciences (SPSS) version 21 software. The analysis was done using SPSS. Quantitative variables were expressed as means, standard deviation and qualitative variables as frequencies and percentages and test of association carried out using Chi-square and Fishers Exact with level of significance set as P<0.05.

Knowledge of Birth Preparedness and Complication

Readiness: A total of six questions was given to the respondents to assess their level of knowledge on Birth Preparedness and Complication Readiness. The questions were collated and graded as follows: those who scored between 3-6 marks (above 50%) were said to have good knowledge, while those who scored between 0-2 marks (below 50%) were said to have a poor knowledge of birth preparedness and complication readiness [16].

Attitude towards Birth Preparedness and

Complication Readiness: A total of seven questions relating to the respondents attitude to birth preparedness and complication readiness. Each response was graded according to Likert scale. Each item score between 1 to 5 points. The options were: 5 points for 'Strongly agree', 4 points for 'agree', 3 points for 'disagree', 2 points for 'strongly disagree', 1 point for 'undecided'. The answers collated were then converted to 1 (Agree and Strongly agree) and 0 (Undecided, Strongly disagree and Disagree). Those who scored between 7-14 marks (50 % and above) were considered as having a positive attitude while those who scored between 0-6 marks (50% and below) were considered as negative attitude towards birth preparedness and complication readiness [16].

Practice of Birth Preparedness and Complication

Readiness: A total of five questions relating to the

respondents practice of birth preparedness and complication readiness (BPCR). A pregnant woman was considered “prepared” for birth and its complications if she reported to follow at least 3 of the 5 basic components of BPCR (that scores between 1-5points) while those who scored between 0-3 points were considered as “not prepared” for birth and its complications [16,17].

Ethical Considerations

Ethical approval for this study was obtained from the Ethical and Research Committee of Lagos University Teaching Hospital .Institutional ethical clearance was obtained and assent granted by the Executive Chairman of the LGA, Medical Officer of Health and Officer In-Charge

of the Primary Health Care Centers .The respondents were assured of their freedom to participate and also to withdraw from the study at any time they wished. Privacy and confidentiality of the respondents information’s was respected during and after the interview. Data were kept secure.

3. Results

The result of 360 subjects, representing the responses of all the pregnant women in the study as presented in Tables 1-8.

Table 1. Socio-demographic characteristics of respondents (N=360)

Socio-demographic	No of Cases	Percentage of total of cases studied
Age (years)		
<21	25	6.9
21-25	57	15.8
26-30	143	39.7
31-35	112	31.2
36-40	12	3.3
>40	11	3.1
Religion		
Christian	149	41.4
Islam	199	55.3
Others*	12	3.3
Ethnicity		
Ibo	118	32.8
Yoruba	194	53.9
Hausa	30	8.3
Others**	18	5.0
Marital status		
Single	47	13.1
Married	292	81.1
Separated/ Divorced	19	5.2
Widowed	2	0.6
Education		
Primary	101	28.1
Secondary	99	27.5
Tertiary	143	39.7
None	17	4.7
Occupation		
Skilled	117	32.5
Semi-skilled	98	27.2
Unskilled	123	34.2
Don’t know	22	6.1
Socio-demographic	No of Cases	Percentage of total of cases studied
Number of weeks pregnant		
1-12 weeks	63	17.5
13-24 weeks	188	52.3
25-40 weeks	109	30.2
History of stillbirth		
Yes	50	13.9
No	310	86.1
Pregnant in the past one year		
No	103	28.6
Yes	257	71.4

Parity(n=257)

Less than 3	83	32.3
3 or more	174	67.7

The mean age group of the respondents is 28.9 $\pm$ 5.3 and majority of the respondents were between the ages 26-30years.

Table 2. knowledge of birth preparedness and complication readiness for study respondents (N=360)

knowledge of birth preparedness and complication readiness	No of Cases	Percentage of total of cases studied
Heard of birth preparedness and complication readiness		
Yes	232	64.4
No	128	35.6
Sources of information (n=232)		
Media(Television, radio, etc)	153	65.9
Health worker(Doctor , Nurse,etc)	227	97.8
Family	61	26.3
Friends	68	29.3
Internet	2	0.9
Total Number of times to attend ANC (n=360)		
One	12	3.3
Two	72	20.0
Three	62	17.2
Four or more	185	51.4
Danger signs during pregnancy		
Severe vaginal bleeding	312	86.7
Severe headache	291	80.8
Blurred vision	143	39.7
Convulsion	149	41.4
Swollen hand and face	146	40.6
High fever	9	2.5
Loss of consciousness	65	18.1
Severe abdominal pain	17	4.7
Accerlated or reduced fetal movement	26	7.2
Danger signs during labour and childbirth		
Severe vaginal bleeding	269	74.7
Severe headache	229	63.6
Convulsion	141	39.2
knowledge of birth preparedness and complication readiness		
	No of Cases	Percentage of total of cases studied
High fever	71	19.7
Loss of consciousness	140	38.9
Labour lasting for more than 12 hours	71	19.7
Danger signs during post-partum		
Severe bleeding	209	58.1
Severe headache	200	55.6
Blurred vision	131	36.4
Convulsion	131	36.4
Swollen hands and face	122	33.9
High fever	119	30.9
Foul smelling vaginal discharge	122	33.9
Loss of consciousness	29	8.1

A great number of respondents 232 (64.4 %) have heard about birth preparedness and complication readiness, while the remaining 128 (35.6 %) have not heard about it.

Table 3. Knowledge of birth preparedness and complication readiness for study respondents (N=360) continues

Knowledge of Birth Preparedness and complication readiness	No of Cases	Percentage of total of cases studied
Attending antenatal care services (n=360)	347	96.4
Identifying skilled provider	229	63.6
Identifying mode of transport	220	61.1
Saving money	279	77.5
Identifying company	141	39.2
Knowledge of death from danger signs (n=360)		
During pregnancy Yes	229	63.6
No	59	16.4
Don't know	72	20.0
During labour and delivery		
Yes	217	60.3
No	58	16.1
Don't know	85	23.6
During post-partum		
Yes	229	63.6
No	59	16.4
Knowledge of availability of community support systems (n=360)		
Financial support system		
Yes	16	4.4
No	344	95.6
Transport system		
Yes	29	8.1
No	331	91.9
Blood donor system		
Yes	3	0.8
No	357	99.2

*Multiple responses allowed

Knowledge of birth preparedness and complication readiness was considered, based on the components of the birth preparedness and complication readiness concept. This means, those who knew the components as a way of preparing for birth and ready for the complications.

Table 4. Level of Knowledge towards birth birth preparedness and complication readiness(N=360)

Level of knowledge towards dangers signs of pregnancy	No of Cases	Percentage of total of cases studied
Poor (0-49%)	261	72.5
Good (50-100%)	99	27.5
Level of knowledge towards birth preparedness and complication readiness		
Poor (0-49%)	131	36.4
Good (50-100%)	229	63.6

A total of 229 (63.6 %) respondent have a good knowledge of birth preparedness and complication readiness while 128 (35.6 %) of the respondents have a poor knowledge of birth preparedness and complication readiness.

Table 5. Attitude towards birth preparedness and complication readiness

ATTITUDE STATEMENT	1	2	3	4	5
Seek medical help if she noticed any danger signs during pregnancy	298(82.7)	41(11.4)	5(1.4)	11(3.1)	5(1.4)
Prepared for birth and its complications by doing the following:					
Attend ANC	269(74.7)	1(0.3)	10(2.7)	-	80(22.3)
Identify a skilled provider	342(95.0)	9(2.5)	1(0.3)	-	8(2.2)
Identify mode of transport	218(60.6)	2(0.5)	40(11.2)	2(0.5)	98(27.2)
Identify company	191(53.1)	69(19.2)	-	-	100(27.7)
Save money	338(94.0)	8(2.2)	4(1.1)	1(0.3)	9(2.5)
Identify blood donor	151(41.9)	9(2.5)	70(19.4)	90(25.1)	40(11.1)

1- Strongly Agree, 2-Agree, 3- Strongly Disagree, 4-Disagree, 5-Undecide

Data presented on this table are number of subjects (n) and proportions (%) of individual and their attitude towards birth preparedness and complication readiness.

Table 6. Attitude score TOWARDS birth preparedness and complication readiness RESPONDENTS (n=360)

Attitude	No of Cases	Percentage of total of cases studied
Positive (<50)	271	75.3
Negative (>50)	89	24.7

Majority of the respondents 271 (75.3 %) of the respondents in this study, showed a positive attitude towards birth preparedness and complication readiness.

Table 7. Frequency Distribution of respondents by number of antenatal visits during pregnancy

Total number times for antenatal care visits during pregnancy	No of Cases	Percentage of total of cases studied
ONE	8	2.2
TWO	10	3.0
THREE	187	51.9
FOUR OR MORE	143	39.7
Means of transportation during delivery		
Private care	69	19.2
Taxi/bus	134	37.2
Motorbike	84	23.3
Boat	12	3.3
On foot	10	2.8
Tricycle	51	14.2
Time of first ANC registration/visit		
First trimester	126	35.0
Second trimester	162	45.0
Third trimester	61	16.9
Practice of BPCR		
Identified skilled provider	159	34.2
Saved money for childbirth(	286	79.4
Arranged for transport to place of childbirth	152	42.2
Identified blood donor	43	11.9
Practice of Birth preparedness and complication readiness		
Prepared (>50)	124	34.4
Not prepared (<50)	236	65.6

Data presented on this table, shows the percentage of cases who have made adequate preparations for child birth.

Table 8. Association of socio-demographic and obstetric factors of respondents with preparation for birth and its complication

VARIABLE	PRACTICE OF BIRTH PREPAREDNESS AND COMPLICATION READINESS		X ²	P-VALUE
	Not prepared (%)	Prepared (%)		
Age(years)				
<21	14(56)	11(44)	27.193	0.176 ^F
21-25	40(70.1)	17(29.8)		
26-30	40(36.8)	103(63.2)		
31-35	41(28.0)	71(72.0)		
36-40	1(8.3)	11(91.7)		
>40	0(0.0)	11(100.0)		
Religion				
Christian	60(40.2)	89(59.7)	22.907	0.0721
Islam	84(42.2)	115(57.7)		
Others	7(58.3)	5(41.6)		
Ethnicity				
Ibo	43(36.4)	75(63.6)	23.861	0.0756
Yoruba	71(36.6)	123(63.4)		
Hausa	17(56.7)	13(43.3)		
Others	13(72.2)	5(27.8)		
Marital status				
Single	30(63.8)	17(36.2)	60.511	0.000 ^{F*}
Married	80(27.4)	212(72.6)		
Separated/divorced	12(63.2)	7(36.8)		
Widowed	2(100.0)	0(0.0)		
Education				
Primary	77(76.2)	24(23.8)	117.71	0.0001 [*]
Secondary	77(77.8)	22(22.2)		
Tertiary	23(16.1)	120(83.9)		
None	7(41.2)	10(58.8)		
Occupation				
Skilled	23(19.7)	94(80.3)	54.696	0.056
Semi-skilled	63(64.3)	35(35.7)		
Unskilled	31(25.2)	92(74.8)		
None	7(31.8)	15(68.2)		
History of stillbirth				
Yes	6(12.0)	44(88.0)	12.954	0.0001 [*]
No	118(38.1)	192(61.9)		
Parity				
Less than 3	54(65.1)	29(34.9)	34.088	0.0001 [*]
3 or more	59(33.9)	115(66.1)		

F=Fishers Exact

X² chi-square

* Statistically significant

There is statistically significant association ($p < 0.05$) between the respondents marital status, educational status, history of still birth, number of children to practice of birth preparedness and complication readiness.

4. Discussion

The study results showed that 236 (65.6 %) of the respondents were aware of birth preparedness and complication readiness, this results is similar to the 655 (70.6 %) from a study carried out in southeastern Nigeria on Awareness of birth preparedness and complication readiness [18]. This could be because; most of the respondents in both studies were educated and informed.

The results obtained in this study show a lower value, compared with 546 (87.4 %) in a study done Edo State Nigeria on the assessment of birth preparedness and complication readiness [19]. The reason for this disparity could be due to the fact that most of the respondents in the study done in Edo state were more aware of the components of birth preparedness and complication readiness and hence seem to be more knowledgeable.

In this study, the two key danger signs during pregnancy which were spontaneously mentioned by the respondents were severe vaginal bleeding 312 (86.7 %) and convulsion 291 (80.8 %). During labour the danger signs mostly mentioned by the respondents were severe vaginal bleeding 269 (74.7 %) and severe headache 229 (63.6 %), this is high when compared results from a study done in Jimma Ethiopia, were severe vaginal bleeding 212 (49.5 %) and convulsion 120 (16.3 %) were mentioned spontaneously as danger signs during labour and childbirth [8]. This difference maybe because the Jimma Ethiopia is a rural area and as such the respondents are likely to be less exposed and illiterate.

In this study only 16 (4.4 %) of respondents had knowledge of financial support systems provided in the community. Community resources were poorly known or recognized by the majority of women, which corroborates with earlier studies in Abia, Nigeria and contrary to what was reported in West Bengal [12, 20]. This could be due to the fact that these studies were unavailable or because information about them was not made available to the mothers. The approach to tackling this problem is to involve and obtain the commitment of local government chairpersons, local community, and opinion leaders, with the aim of strengthen the existing service; so as to be able to provide local transport, blood donors and emergency funds through community health funds. The local media, grass-root faith-based organizations, and nongovernmental agencies can be involved to carry out information dissemination as well.

In this study, 271 (75.3%) of the respondents had a positive attitude towards birth preparedness and complication readiness. This is in contrast to a study done

in India where 453 (53.3%) of the respondents showed a favorable attitude to birth preparedness and complication readiness. This disparity could be because the respondents in the study done in India were less educated and as such will likely show a negative attitude to birth preparedness and complication readiness [21].

The overall result of birth preparedness and complication readiness index was graded as prepared for birth and its complications and not prepared for birth and its complications. In this study, 124 (34.4 %) of the respondents were prepared for birth and its complications. This is in contrast to a study done in Indore, India, where 321 (47.8 %) of the respondents were well-prepared for birth and its complications [22]. In a community based cross-sectional study done in Chamwino district, in Tanzania, 234 (58.2 %) of the respondents were considered as prepared for birth [16]. There is also similarity seen in a study done in Mbarara district Uganda where 128 (35 %) of the respondents were well prepared [5].

In this study, factors associated with birth preparedness and complication readiness are: level of education ($p=0.0001$), history of still birth ($p=0.0001$), and Parity ($p=0.0001$) which emerged as the predictors of the respondents' readiness for complications. This finding agrees with that of Hiluf and Fantahun from Ethiopia, where preparation for birth and its complication was found higher among literate mothers, women with parity range of 2 to 4, women with history of stillbirth, and those who were advised about birth preparedness during their antenatal care follow-up [13].

5. Conclusions

Generally, a number of 229 (63.6 %) of the respondents in this study, have a good knowledge of birth preparedness and complication readiness components. This study showed that the number respondents 271 (75.3 %) had a positive attitude to birth preparedness and complication readiness components. The practice of birth preparedness and complication readiness components at 124 (34.4%) shows that despite the respondents good knowledge and positive attitude, they still do not practice birth preparedness and complication readiness. This study revealed that the proportion of pregnant women who prepared for birth and were ready for its complications was not satisfactory. Repeated awareness programs should be initiated at the Primary Health Care centers towards community participation so that Birth Preparedness and Complication Readiness status improves for these women. This will be a positive step toward achieving the millennium development goal 5, of safe motherhood and reduction in maternal mortality. Birth preparedness and complication readiness, as components of focus antenatal care are an important concept that will significantly reverse the current trend of maternal morbidity and mortality

experienced in our community if strictly followed. Birth preparedness and complication readiness involves not only the pregnant woman, but also her family, community, and the available health care providers. Therefore, they need to collaborative in their efforts to support this group of people, for a robust, effective and efficient health care delivery. Therefore, to reduce the economic implications as a result of maternal death in Nigeria, health and policy stakeholders, together with the community must take adequate steps to ensure early education among the girls at young age, providing adequate blood bank services and engaging in constant researches in the field of birth preparedness and complication readiness.

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