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.

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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