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DETERMINANTS OF BIRTH PREPAREDNESS AND COMPLICATION READINESS: A QUALITATIVE STUDY AMONG MIDWIVES IN SELECTED PRIMARY HEALTH CARE FACILITIES IN ONDO STATE, NIGERIA

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Abstract

Maternal mortality remains an unresolved issue in public health, with birth readiness and complication readiness playing a crucial role in addressing this concern. Birth readiness involves preparing for a routine delivery, while complication readiness entails planning for emergency situations. Pregnancy and childbirth-related complications, which can lead to short-term or long-term diseases and even death, affect a significant number of women in low-income countries, approximately 300 million. This qualitative study examines the determinants of Birth Preparedness and Complication Readiness among pregnant women in selected primary healthcare (PHC) facilities in the South Senatorial districts of Ondo State, Nigeria. The study involved eight midwives from two purposively selected PHC facilities in Ondo State. A phenomenological approach was employed, and data were collected through interviews using an interview guide. NVivo version 11 was utilized for data analysis, employing thematic qualitative analysis to identify emerging themes. The findings of this study revealed one main theme and seven subthemes related to the determinants of Birth Preparedness and Complication Readiness. These determinants encompassed culture, the financial status of the respondents, religion, peer group influence, ignorance, the age of pregnant women, and the attitude of healthcare providers. These identified determinants highlighted the barriers that hinder pregnant women from embracing Birth Preparedness and Complication Readiness practices. To enhance the effectiveness of future interventions related to Birth Preparedness and Complication Readiness, it is recommended that midwives increase awareness among pregnant women. Additionally, greater emphasis should be placed on the quality of information provided to expectant women during prenatal care visits, with particular attention given to women from economically disadvantaged backgrounds.

Keywords: Birth preparedness, Complication readiness, determinants, midwives

INTRODUCTION

Maternal mortality remains an unresolved issue in public health, with significant global implications. In 2017, the global maternal mortality ratio was reported as 211 per 100,000 deliveries, resulting in a total of 295,000 maternal deaths during and after childbirth. Sub-Saharan Africa and South Asia accounted for approximately 86% of these deaths worldwide (WHO, UNICEF, & UNFPA, 2019). Nigeria, in particular, has a high maternal mortality ratio, estimated at 814 per 100,000 live births in 2015, contributing to approximately 40,000 maternal deaths annually and 14% of the global aggregate (WHO, UNICEF, 2019).

Although evidence-based interventions for preventing maternal deaths are available, birth preparedness and complication readiness (BPCR) remain significant challenges in underdeveloped nations. While developed countries have made progress in this area, low BPCR rates persist in developing countries, contributing to high rates of maternal mortality (Ananche, 2020; Mehboob, 2021) (Kiataphiwasu, 2018 & Ihomba et al., 2020).

Various barriers hinder pregnant women from accessing essential care and practicing BPCR in developing countries. Illiteracy, ignorance, socio-cultural beliefs, structural issues and financial constraints are some of the challenges identified in the literature (Ketema et al., 2020; Ehiemere et al., 2017; Bintabara et al., 2019; Anikwe et al., 2020). Illiteracy in particular, has been recognized as a significant barrier to BPCR, as demonstrated by recent studies (Ketema et al., 2020). Additionally, younger

age at pregnancy may limit women's ability to adequately prepare for childbirth (Ehiemere et al., 2017). The occupation of being a housewife and transportation issues have also been found to hinder BPCR practices (Bintabara et al., 2019; Anikwe et al., 2020).

This study is motivated by the existing literature highlighting poor knowledge of BPCR among women attending primary healthcare facilities in Ondo State, Nigeria. Furthermore, only 45% of registered antenatal attendees in the state delivered in healthcare facilities, raising concerns about the non-utilization of BPCR and the need to address determinants contributing to maternal mortality (Ondo State Primary Health Care Development Board, 2021 statistics). Thus, this study aims to explore the determinants of birth preparedness and complication readiness among pregnant women in selected primary healthcare facilities in Ondo State, Nigeria, employing a qualitative approach.

METHODOLOGY

The research design chosen for this study is qualitative approach. Information was explored on opinion of midwives in the determinant of BPCR practice among pregnant women. The study was conducted in Primary Health care (PHC) facilities located in two local government areas (LGA) (Ile Oluji and Odigbo LGA) of South Senatorial district of Ondo State, Nigeria. Participant's consent was equally gained.

The study focused on midwives who provide care to pregnant women in the antenatal clinic of Ile Oluji and Odigbo Primary Health Care Centre. The inclusion criteria for participants were as follows: registered midwives with a minimum of two years of experience in the state and currently working in the antenatal section of the selected primary healthcare facilities.

The eligible midwives who met the criteria were invited to take part in the study. Key informant interviews (KIIs) were conducted at mutually agreed upon convenient times and locations. A combination of data collection methods was employed, which included KIIs using a KII guide, digital recorder, and field notes to capture the pertinent research information. The duration of each interview ranged from 25 to 30 minutes, and the entire procedure was recorded using an audio tape. Data collection took place between August and December 2022. To ensure confidentiality, a unique code number was assigned to each participant for identification purposes.

The study adhered to the rules and regulations outlined in ethical guidelines for research and received approval from the Institutional Review Board of Babcock University's Ethical and Research Committee, with approval number BUHREC637/22 dated 5th August 2022. Prior to data collection, permission was obtained from the Permanent Secretary of Ondo State Primary Health Care, Ondo State, with approval number OSHREC/21/07/22/461, as well as the Matron in charge of the selected Primary Health Care centres. The participants were fully informed about the purpose of the study and provided with an informed consent form to review and sign. The confidentiality of their information was emphasized, and they were assured that all data collected during the study would be kept private. To ensure confidentiality, all collected information was stored securely on the researcher's laptop computer, protected with a password. During the study, the participants' privacy and confidentiality were respected, and their rights were upheld. The participants were given the freedom to choose the time and place of the interview to further safeguard their confidentiality. All participants were treated with respect to ensure fairness and justice throughout the study.

Data analysis

The data obtained from the interviews were transcribed verbatim by two independent experts who specialize in qualitative research. The transcribed data were then entered into

NVivo version 11, a qualitative data analysis software, for further analysis. The opinions expressed by the midwives regarding the determinants of birth preparedness and complication readiness were identified, highlighted, and coded based on words, phrases, and statements found in the discussions. These codes were organized into themes that informed the thematic content analysis, which aimed to explore the midwives' opinions on the determinants. The analysis process followed the principles of saturation, ensuring that enough data had been collected to adequately address the research questions. The analysis involved several steps: organizing and preparing the transcribed data, transcribing the interviews conducted in the Yoruba language, translating the Yoruba transcripts into English, reading through the transcripts, using NVivo 11 for categorization, presenting themes in sections and subsections, incorporating direct quotes from the transcripts for emphasis, and generating categories and coding the data. This rigorous process ensured that the data were thoroughly analyzed and that the midwives' perspectives on the determinants of birth preparedness and complication readiness were accurately represented.

Trustworthiness of the study

In qualitative research, it is paramount that data collected from participant and reported on is trustworthy. Identified the importance of validity in qualitative research to assess for and ensure both the accuracy and credibility in research finding. There are three important areas in qualitative research that were addressed to mitigate issues of trustworthiness. These four areas are credibility, transferability, dependability and confirmability.

To ensure credibility, we confirmed that the data collected from respondents was true and correct. To ensure clarity and improve knowledge, respondents were encouraged to give accurate answers to all questions by using probing iterative questioning. Similarly, to achieve dependability the researcher submitted the collected data to the expert co-coder for comparison of data and analysis. We also conducted an audit trail by keeping a comprehensive record of the data collection process and meeting with participants at the research setting to discuss the study's findings and recommendations with them to ensure that the data they provided during the data collection process is accurate.

To achieve confirmability, the authors used audit trails in which the approaches to data collection, decisions about which data to collect, and the interpretations of data were carefully documented so that another knowledgeable scholar could reasonably have arrived at the same conclusions about data as the primary researcher. We ensured that the findings reflected the participants' voices and the conditions of inquiry, rather than the biases, motivations, or perspectives of the researcher. Similarly, we ensured that there was an internal agreement between the researcher's interpretation and the actual evidence. To guarantee transferability, the authors provided a comprehensive description of the nature of the study participants.

RESULTS

Table 1: Socio-demographic characteristics of the Respondents in Key informant Interview

Participants	Age	Designation	Qualification	Years of Experience	Religion	Marital Status	Academic qualification
Facility							
1	35	PNO	RN, RM, BSc	10	Christianity	Married	BNSc
1	50	ACNO	RN, RM	25	Christianity	Married	Diploma
1	35	PNO	RN, RM	12	Christianity	Married	BNSc
1	42	ACNO	RN, RM	15	Christianity	Married	Diploma
2	28	NO I	RN, RM	05	Christianity	Married	Diploma
2	40	PNO	RN, RM, BSc	15	Christianity	Married	BNSc
2	45	ACNO	RN, RM, BSc	18	Christianity	Married	BNSc
2	36	PNO	RN, RM, BSc	13	Christianity	Married	BNSc

Key: NO 1 - Nursing Officer 1; PNO -Principal Nursing Officer: ACNO-Assistant chief Nursing Officer: F1 - Facility 1: F2 - Facility 2: KII Key informant interview; P1 - Participant 1; F1 - Facility 1; F2- Facility 2

Table 1 presents the socio-demographic characteristics of the eight participants who took part in the Key Informant Interview. The participants consisted of four individuals from each of the two selected primary health care facilities. The age of the participants ranged from 28 to 50, and all of them were married. They held professional qualifications as Registered Nurses (RN) and Registered Midwives (RM), with a minimum of five years of working experience. All participants identified as Yoruba and practiced the Christian faith.

Table 2: Themes and Subthemes generated from data on the determinants in selected health facilities in Ondo State, Nigeria.

S/N	Construct	Theme	Sub-Themes
1	Opinion of Midwives on BPCR determinants	Barriers to BPCR practices.	• Financial Challenge • Culture • Ignorance • Attitude of health workers • Age of pregnant women • Location of health facilities

7One inductive thematic category structured the meaning of the determinants of pregnant women towards the practice of BPCR. Therefore, to explain the determinants of pregnant women towards the practice of BPCR birth preparedness and complication readiness we based our analysis on the following themes which formed the determinants towards the practice of BPCR. The following sub themes were identified as determinants.

- Financial status of respondent,
- Peer group influence
- Ignorance
- Age
- Attitude of health care provider
- Culture

These structured the five thematic categories explained the determinants of pregnant women towards the practice of birth preparedness and complication readiness.

Theme 1: Financial status

According to the midwives interviewed, finance emerged as a significant barrier to the adoption of birth preparedness and complication readiness (BPCR). Many pregnant women in the study area were reported to opt for traditional birth attendants (TBAs) instead of skilled birth attendants due to financial constraints. The lower cost associated with TBAs was cited as the primary reason for this choice. However, relying on TBAs increased the risk of pregnancy-related complications for these women. The financial aspect was identified as a major factor influencing adherence to BPCR. In the study areas, a considerable number of pregnant women were housewives without employment, relying solely on their husbands for financial support. Consequently, this financial dependency hindered their ability to engage in antenatal booking and other essential activities at the clinic, as reflected in the following quotes.

"Most times finance is a major factor in the practice of BPCR. Some of the pregnant women claimed that their husband refused to give them money as most of them are house wives they don't do anything for a living. Yes…..finance, if you ask them a token of 10 naira or 200naira to carry out an investigation is a problem to some of our clients. Even when some of the services are free, they have the mind that anybody going to the hospital have to pay through their nose" **(KII P3, F1)**

"Fund, most of our pregnant women complained about not having money. They usually complain that the hospital fees are expensive. Ah, well you know without fund you cannot do anything, at least they will pay for laboratory test when they get to the hospital. They may not get money to do the test and the test is very compulsory **(KII.P1, F2)**

"Money is the wheel of evangelism. The major problem affecting birth preparedness and complication readiness in this setting is poverty; I have seen a serious case where the pregnant woman in labour did not bring anything. I have to go and buy things when they called me that so so and so….is in labour." **(KII P2 F1)**

"Issue of cost of services is also one of the problems, there are some pregnant women that cannot afford three square meals. That is why we have arrangement for indigent patients. Most times we identify them as a group that need support and we advise them to come regularly for antenatal care as we provide for their basic needs" **(KII P1 F2)**

Theme 2: Peer Group Influence

According to the respondents, peer groups play a significant role in decision-making, including among pregnant women. The experiences and recommendations of others hold considerable influence. In some cases, pregnant women choose not to register for antenatal care and instead prefer visiting alternative providers such as traditional birth attendants (TBAs) or seeking advice from their peers. Additionally, the influence of the mother-in-law was highlighted, as their living experiences often shape the decision-making process. Many mothers have the ability to influence their daughters' decisions based on their own experiences, as illustrated in the following quotes.

"Peer group influence some of them, majority listen so much to friends and will like to follow their instruction. Some even encourage them to visit Traditional birth attendants and they made them see reasons why they must visit Agbebi. Others take instruction that is contrary to what they are been taught at the antenatal clinic from their neighbours **(KII P2, F2).**

> *"Then peer group influence some of them, most of the time they listen to their friends, mothers, and mother in-law more that the midwives. Some are introduced to traditional birth attendants and Agbebiye homes by friends. Most of the time after listening to health workers in the hospital they still follow wrong advice from their friends. They do convince the pregnant women to deliver in mission homes and claiming its cheaper to that of hospital.* **(KII P4, F2)**

Theme 3: Ignorance

According to the midwives' observations, a significant number of pregnant women exhibit a lack of knowledge regarding birth planning and complication readiness. They emphasized that it is crucial for pregnant women to begin preparing adequately as soon as they realize they have missed their period. Many pregnant women fail to proactively plan their lives, including their desired number of children and how to provide for them. Instead, they rely on circumstances and events as they unfold, which often leaves them unprepared and facing challenges during their journey through life. Without a clear plan regarding the number of children and how to care for them, it becomes difficult to effectively plan for childbirth and ensure readiness for potential complications, as highlighted in the following quote.

> *"Ignorance on the part of our clients, even after preaching and preaching to them they still want to listen to their friends, they still want to listen to their 'Iya oko' (mother-in-law) for advice. We also advice that they come with the person that will accompany them to hospital. Many times you are teaching them one thing another person is giving them contrary information at home* **(KII P2, FI)**
>
> *"Another factor is ignorance, most of the pregnant women here are not educated, the highest level of education is Junior JSCE (Junior secondary certificate examination). Their means of livelihood is majorly farming and trading. So many of the times during antenatal contact, you may need to repeat over and over before they can understand* **(KII P1, F2)"**

Theme 4: Age of pregnant woman

Age is an important variable that determines so much health variables. Age of respondent matters in adhering to birth preparedness and complication readiness. The respondents mentioned that young pregnant women tend to have problem in making decision and often make a rational decision. Some pregnant women who married early or had unplanned pregnancy find it difficult to make preparation on birth and getting money ready is more difficult since they are young and many of them do not even have any husband responsible for

the pregnancy. So, age is also a determining factor of birth preparedness and complication as shown in the following excerpts.

> *"Age, yes; it could be the age of the mother, is it under age emmm… teenage mothers? So, you know in that situation majority of them can't make decisions on their own, we have so many of them as our patients here. Some are still living under the roof of their parents and they become pregnant.* **(KII P3, F1)**

> *"Number one is age; it could be the age of the mother, is she under age emmm… teenage mothers? Some don't even know their right from left., some are drop out from school. At times some are followed to the clinic by their mother. majority of them can't make decision on their own,* **(KII P2, F2)**

> *"Age is another factor as most teenage pregnant girls are victim of rape or may not know who is responsible for the pregnancy, so in that situation we have a lot to contend with, they were even forced to come and register in the first place"* **(KII P3, F2)**

Theme 5: Attitude of Health Care Workers

The attitude of health workers has emerged as another significant determinant of birth preparedness and complication readiness among pregnant women in the study areas. It was reported that some health workers exhibit rudeness towards pregnant women, which negatively impacts their interest in registering at health centers. Respondents suggested the need to provide further education to health workers on how to establish a positive relationship with their clients, as their attitude can either drive pregnant women away or encourage them to seek care at the health facility. Many participants shared feedback from pregnant women who felt mistreated by midwives and nurses, leading them to seek the assistance of traditional birth attendants who are perceived as more compassionate and caring. Therefore, the attitude of health workers has the potential to significantly influence the level of birth preparedness and complication readiness among pregnant women.

> *"Thank you very much, you know our health workers, we would just continue to preach the gospel to the midwives, most of the time the workload is much and they may be rude to patients. This singular act can prevent pregnant women from coming to the facilities* **(KII P3 F2)**

> *"Of a truth some health workers are very harsh and disrespect patients during labour and antenatal session. For some, if pregnant women called them while in labour, they may not answer them. Midwives needs to ensure good communication strategies when dealing with their patients* **(KII P2, F1)**

> *"Most of the time attitude of our midwives is not reflecting the training they have received. Am sorry to say this, not all midwives sha… if you say you are a midwife and you have all these trainings yet when pregnant women come to you and they do not see you showing them this empathy and you're not treating them as somebody who cares or somebody who empathizes with them, them this can discourage them from coming to hospital.* **(KII P1, F1)**

> *"When you are talking about social determinants of disease "You have to talk about what are those things that would influence health seekening behavior of these people. Is it the uniqueness of the health facilities if you say it is unique then the human resources must be adequate, the environment must be attractive? Beyond that the attitude of the health workers must be so pleasant such that these people will find themselves safe*

and not otherwise" **(KII P4 F2)**

"Of a truth, some midwives not all often treat patient with disdain, it may be as a result of workload coupled with shortage of midwives, just look at this facility now, we run our ANC two times in a week and looking at the number of patients. But of a truth, midwives' attitude can either make the pregnant women come or run away from the centres. "Attitude of the health workers must be so pleasant and encouraging such that these people will find themselves safe" **(KII P1F2)**

"Of a truth some midwives are very harsh and disrespect patients during labour and antenatal session. Some of the pregnant women do complain to me and we are trying our best to ensure that midwives treat pregnant women with respect. I have heard situation where pregnant women will call midwives in labour and they will not answer. So you see... this may affect their choice of not seeking hospital services which is a major aspect of BPCR. Midwives needs to ensure good communication strategies when dealing with these pregnant women and accord them respect. Good attitude will definitely improve patients' knowledge and practice of BPCR" **(KII P3 F2)**

Theme 6: Culture

Culture has been identified as a significant factor affecting the adoption of birth preparedness and complication readiness (BPCR) among pregnant women. It encompasses the beliefs, customs, and social behaviors of a particular society or group of people. According to the respondents in this study, cultural beliefs and practices influence the attitudes of pregnant women towards the recommendations provided by healthcare professionals. For example, some African cultures prioritize having a large number of children, even when the means to care for them may be limited. The influence of family and the beliefs passed down from previous generations also play a role, as women may adhere to practices based on what their mothers have taught them. These cultural factors can hinder the participation and adherence to obstetric care among pregnant women in Ondo State. Additionally, cultural norms regarding the ideal number of children can put women at risk during childbirth, as the pressure to have multiple children may overlook the importance of ensuring their health and well-being..

"Cultural practice is another barrier to the practice of Birth planning and ..... sone group in this community don't believe in buying baby items until the child is born, this has been a great challenge to us in this facility. They claimed that they must give birth to (the baby before the purchase of delivery items and baby things ***(KII P3.FI)***

"Some of the pregnant women forbid the issue of taking blood, anytime you raise it during clinic, their response is usually 'God forbid' they will tell you they don't take blood in their lineage. This has really made complication readiness practices difficult in this location **(KII P1 F1)"**

"Some mother-in-law prefer to take the delivery by themselves, and some will tell their daughters or daughter in law that they gave birth to their husband in traditional birth homes. All these factors are impediments to the practice of birth preparedness and complication readiness. **(KII P3 F2)"**

DISCUSSION

The content analysis explored the determinants of BPCR practice among pregnant women and results showed that finance, religion, peer group influence, ignorance, age, attitude of health care workers and culture. This was consistent with the study of Ketema, (2020) and Silwal (2020) where illiteracy, ignorance,

socio-cultural belief, structural issues and financial constraints were identified as determinants peculiar to low-income countries. The findings of Ope (2020), also revealed that most pregnant women avoid going to health facilities since their husbands don't provide enough financial support because the majority of them do not have jobs, which makes it difficult for them to get ready for childbirth.

The barriers identified in our study align with the findings of other studies conducted in Sub-Saharan African nations. These studies highlighted various barriers to birth preparedness and complication readiness, including individual characteristics and perceptions, household-related factors, and community-level barriers. The socio-demographic characteristics, perception, and attitude of women, as well as wealth status, tradition and culture, availability of transport facility, societal stigma, and access to relevant community resources and sensitizations were all identified as significant barriers to BPCR (Ope, 2020; Zepre, 2017).

Furthermore, the issue of illiteracy emerged as a major obstacle in the effective utilization of BPCR among pregnant women, which is consistent with the findings of previous studies. Several literatures reviewed on the barriers of BPCR in developing countries highlighted illiteracy and ignorance as barriers to the practice (Silwal, 2020; Ijang, 2019). It is crucial to continuously create awareness and provide education to women of childbearing age, particularly in low-resource areas, about the importance of recognizing danger signs in pregnancy, labor, and postpartum, as well as the components of birth preparedness and complication readiness.

A comparative analysis across selected countries, including Ethiopia, also revealed a low level of BPCR practice. Barriers identified in these contexts included ignorance about the importance of health facility delivery, lack of funds, and inadequate preparation for blood donation in emergency situations (Zepre, 2017; Berhe, 2018). These findings further emphasize the need for targeted interventions and comprehensive education programs to address these barriers and promote effective BPCR practices in various settings.Participants also opined that attitude of health care workers as one of the determinants of BPCR, this was supported by the finding from another study in East African country, the study revealed that less than half of the women interviewed in a cross-sectional study conducted in Ethiopia, practiced complication readiness and birth preparedness and more than three-quarter of pregnant women were not well prepared for delivery and its consequences by health workers (Limenih, 2019). The findings of Ijang (2019) were different with the outcome of this study as he reported that two additional characteristics identified as potential causes to the poor practice were shortage of community health workers in this health region and inadequate information from healthcare practitioners. Aside from aforementioned barriers, avoiding abuse and disrespect from healthcare professionals, failing to recognize difficulties, and fear of getting a disease while in a healthcare facility were all mentioned in the literature as determinants.

In our study, we found that the age of pregnant women played a significant role in the effective implementation of birth preparedness and complication readiness. Young pregnant women, in particular, faced challenges in decision-making and adequate preparation for childbirth. This was observed among those who married at a young age or experienced unplanned pregnancies, as they often lacked the financial resources and support from a partner to adequately prepare for childbirth. The findings of our study are consistent with the research conducted by Ananche (2020), which identified age, family income, educational achievement, and awareness of obstetric risk indicators as factors linked to the determinants of birth preparedness and complication readiness. This further supports the notion that age is an important determinant influencing the adoption and practice of BPCR

among pregnant women. Understanding the specific challenges faced by young pregnant women can help inform interventions and strategies to improve birth preparedness and complication readiness among this vulnerable group. Efforts should focus on providing comprehensive support, education, and resources to empower young pregnant women to make informed decisions and adequately prepare for childbirth.

Findings from previous studies have highlighted the lack of transportation as a barrier to women's preparedness for birth (Ananche, 2020; Ehiemere et al., 2017). Additionally, the distance between pregnant women's residences and healthcare facilities can be a determining factor in the practice of birth preparedness and complication readiness. Women who live far from health facilities may face difficulties in accessing care during labor and emergencies. It is important to note that the opinions and findings mentioned above may not represent the views of all midwives in Nigeria, as they are based on a small sample size typical of qualitative studies. In low-income settings, particularly in Africa, cultural factors heavily influence the practice of birth preparedness and complication readiness. The patriarchal culture and societal norms in Africa have limited women's autonomy, affecting their decision-making power. Women's readiness for childbirth, especially in terms of financial planning and transportation to healthcare facilities, can be hindered by cultural restrictions that prohibit women from making decisions regarding family and childbirth (Tancred et al., 2016; Shimpalu et al., 2017; Noor et al., 2022). These findings align with the observations made in this study.

CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

In this study, the opinions of midwives regarding the determinants of birth preparedness and complication readiness (BPCR) varied among participants, but certain factors were commonly identified. These determinants included culture, the attitude of healthcare providers, ignorance, age, and peer group influence. Among these factors, finance was consistently highlighted as a major challenge in the practice of BPCR among pregnant women.

The study suggests that healthcare teams should prioritize creating awareness and providing adequate prenatal education to pregnant women during antenatal services in order to reduce maternal mortality. The findings of the study can be utilized to guide nursing practice, inform stakeholders, and influence policy makers. Midwives are recommended to offer comprehensive prenatal education to pregnant women, focusing on the components of birth preparedness and complication readiness, as well as providing information on recognizing danger signs during pregnancy, labor, and the postpartum period.

Stakeholders should ensure that midwives have a supportive work environment to effectively fulfill their roles. Additionally, creating awareness through social media platforms and strategically placing educational posters can help educate the public about the risks associated with seeking healthcare from unqualified individuals.

Policy makers are encouraged to increase the number of midwives in primary healthcare facilities, as this would enable them to deliver adequate antenatal care and education to all pregnant women. It is also important for policymakers to implement policies and programs that provide educational support for midwives, including opportunities to attend local and international workshops and seminars. By addressing these recommendations, improvements can be made in promoting birth preparedness, complication readiness, and ultimately reducing maternal mortality.

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