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FACTORS AFFECTING ACCEPTANCE OF CAESAREAN SECTION AMONG CHILDBEARING AGE WOMEN IN EBUTE-METTA, LAGOS MAINLAND LOCAL GOVERNMENT IN LAGOS STATE, NIGERIA.

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ABSTRACT: *The research study was centered on investigating the factors affecting the acceptance of CS among childbearing age women in Ebute-Metta, Mainland Local Government of Lagos State, Nigeria. The descriptive survey design and simple random sampling and purposive sampling technique was used to elicit information from 138 women attending Antenatal Clinic in Federal Medical Centre, Ebute Metta; State Health Centre, Ebute Metta; Primary Health Care Centre; St. Annes Infirmary for Women, Dawodu Lane, Ebute-Metta; Redeemed Christian Church of God Maternity Centre, Ebute Metta, out of which 129 was returned and dully filled. Data was analyzed using frequency tables, percentage, mean and Standard Deviation. Chi-Square statistical tool was used to test hypotheses. Result revealed that 94.6% of the respondents have high knowledge of CS as a method of delivery. 30.3% of the respondents agreed that CS is preferable to vaginal delivery as the pain in vaginal delivery is usually unpleasant, 55% agree that CS cost more than vaginal delivery. 49.7% of the respondents have experienced CS. Statistically, Knowledge of CS will significantly affect acceptance of CS among women of Childbearing age at X2= 65.163; df=22; p-value 0.000<0.05. Cultural belief will significantly affect acceptance of CS among women of Childbearing age at (X2= 88.271; df= 43; P-value 0.000<0.05. It was therefore concluded that Mothers should therefore be educated on the process involved in Caesarean Section delivery and the advantage, causes, importance of this method of delivery in saving the life of mother and baby. It was recommended that a well-organized and structured education / counselling session be organised during antenatal visit in order to help increase useful information about Caesarean section.*

KEYWORDS: Caesarean Section, Perception, Knowledge, Cultural Beliefs, Cost, Experience and Acceptance.

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INTRODUCTION

Caesarean section (CS) is the extraction of a foetus through surgical incisions in the anterior abdominal wall and the uterine wall after the age of viability (Ebeigbe & Ilesanmi, 2003; Jaiyesimi & Ojo, 2003; Jeremiah, Nonye-Enyidah & Fiebai, 2011). CS is usually performed when vaginal birth is deemed hazardous either to the foetus or the mother and there is no doubt that it has contributed to improved obstetric care throughout the world. CS was introduced in clinical practice as a lifesaving procedure both for the mother and the baby. It is one of the oldest operations in obstetric practice performed upon women dying in the last few weeks of pregnancy in the hope of saving the child as decreed by the Roman law. Nevertheless, the surgery in ancient times was performed on dead women until in the sixteenth century when Jacob Nufer, a Swiss pig farmer, saved the life of his wife who had obstructed labour by the procedure (Cunningham, Leveno, Bloom, Hauth, Dwight & Spong, 2010).

This increase in CS rate has been attributed to many factors in the developed countries, like the fear of malpractice litigation on doctors, more liberal use of CS for breech presentation, the detection of foetal distress by continuous electronic foetal monitoring, abdominal delivery of growth-retarded infant, reduction in operative vaginal deliveries, rise in labour induction rates especially among nulliparous, the increased prevalence of obesity, the increased in caesarean delivery for women with preeclampsia, concern for pelvic floor injury associated with vaginal birth, medically indicated preterm birth-to reduce the risk of foetal injury, patient request and improved safety of CS, among others (Cunningham *et al.*, 2010).

On the contrary, the reasons are less clear in developing countries. In Nigeria, for example, in spite of the high incidence of CS and increasing rate noted in many studies, there is scarcity of text (literature) on why there is this increase in CS rate (Oladipo, Sotunsa & Sule-Odu, 2004). In most Nigerian teaching hospitals, the leading maternal indications were when the baby's head or body is too large to fit through the mother's pelvis, two or more previous CS, eclampsia, failed induction of labour, placenta praevia, severe pregnancy-induced hypertension, and obstructed labour. Major foetal indications include foetal distress, breech presentation, foetal macrosomia, and pregnancy complicated by multiple foetuses (Ugwu, Obioha, Okezie & Ugwu, 2011).

Among women in developing countries, CS is still being perceived as a 'curse' of an unfaithful woman (Adeoye & Kalu, 2011). The authors further asserted that CS is seen among weak women. In addition, CS is surrounded with suspicion, aversion, misconception, fear, guilt, misery and anger among the women of South Western Nigeria (Adeoye & Kalu, 2011). More so, it is significant because it identifies the various factors that have affected acceptance of CS among women of childbearing age in Ebute-Metta, Mainland Local Government Area of Lagos State. The study is also significant as it reveals the perception and knowledge about CS among women of childbearing age in *Ebute Metta in* Mainland Local Government Area of Lagos State. The main objective for this study is to find out factors affecting the acceptance of CS among childbearing age women in Ebute-Metta while specific objectives attempted to:

i. find out if perception is a factor affecting acceptance of CS.

ii. find out if level of Knowledge is a factor affecting acceptance of CS.

iii. determine if cultural belief is a factor affecting acceptance of CS.

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iv. determine if the cost of CS is a factor affecting acceptance of CS.

This study will attempt to test the following hypotheses:

H_{o1}: Knowledge of CS will not significantly affect acceptance of CS among women of childbearing age.

H_{o2}: Cultural beliefs will not significantly affect acceptance of CS among women of childbearing age.

This research will specifically focus its attention on the factors affecting acceptance of CS among women of childbearing age, and due to the logical point that not every Nigerian can be studied; the scope of this research therefore covers Health facilities located in Ebute-Metta in Mainland Local Government Area of Lagos State.

LITERATURE/THEORETICAL UNDERPINNING

Caesarean section (CS) is the delivery of a foetus through a surgical incision into the uterine wall after 28 weeks of gestation (Ashimi *et al*., 2013). A CS is a surgical procedure to deliver one or more babies. It is usually performed when a vaginal delivery would put the baby's or mother's life or health at risk (Habib *et al.,* 2011). It was reported sporadically throughout medical history and was only rendered safe for both mother and foetus during the 20th Century. It is the most commonly performed major obstetric operation in the world and there is no doubt that it has contributed to improved obstetric care throughout the world CS is usually performed when vaginal birth is deemed hazardous either to the foetus or the mother (Nkwo & Onah, 2002; Ashimi *et al*., 2013). Pregnancy and delivery are considered as normal physiological state women. Of all deliveries approximately 10% are considered high risk, some of which may require CS (Kushtagi & Guruvare 2008; Habib *et al.,* 2011). It can be life-saving and is also a highly effective procedure for preventing complications such as dystocia. The WHO stated, in 2015, that every effort should be made to provide CS to women in need, rather than striving to achieve a specific rate (Ji *et al.*, 2015). Due to most women's ignorance about childbirth, they just submissively do what their provider tells them to. Therefore, they can not effectively talk about birth interventions with their providers, and agree for caesarean delivery for medical and even non medical reasons without knowing the true risk and benefits of the procedure.

Indication for CS

The indication related to the size of the baby, foetal position and concern about foetal compromise, but few women were clear about the precise reason for operative delivery. The proliferation of CS deliveries in the past 20 years has been attributed predominantly to non-obstetric factors, including increased use of birth technology, fear of litigation, financial incentives, and physician preference. Major indications for CS in Africa include abruptio placentae, previous CS, foetal distress, malpresentation, preeclampsia/eclampsia, placenta praevia, prevention of HIV infection in the newborn and, most commonly, obstructed labour (Abiodun, Ijaiyi & Aboyeji, 2007 as cited in Ugwu & De Kok, 2015). In the absence of CS, obstructed labour may result in major perinatal and obstetric complications which greatly affect quality of life, including vesico-vaginal fistula (VVF), recto-vaginal fistula (RVF), and stress

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incontinence. Ultimately, obstructed labour can result in death of the mother and baby (Dolea & Zahr, 2003; Ugwu & De Kok, 2015).

Incidence of CS

The incidence of caesarean deliveries at the University of Nigeria Teaching Hospital is 25% with elective caesarean section constituting 21.3% of all caesarean deliveries (Okezie, Oyefara & Chigbu, 2007; Okeke *et al*., 2013). There is a growing opinion that elective caesarean section should not be done before 38 weeks unless there is evidence of foetal lung maturity to avoid adverse neonatal outcomes (Treffers, 1993: Okeke *et al*., 2013). Several studies have documented high incidence of respiratory problem, the newborn special care unit admission, prolonged hospitalisation, low Apgar score, iatrogenic prematurity, surfactant deficiency, and transient tachypnoea of newborn (Donaldson & Dagbjatson, 2007), following elective caesarean delivery (Okeke *et al*., 2013).

Complications of CS

According to Eifediyi *et al.* (2015), the complications of CS include haemorrhage, wound infection, injury to bowel, bladder, ureters or the foetus. Rarely there could be thromboembolism and anaesthesia-related complications. Maternal mortality is extremely low and is estimated to be less than 0.33 per 1000. It is usually related to the reason for which a CS is done or due to anaesthetic or haemorrhagic complications Arulkumaran, (2007).

Factors Affecting the Acceptance of CS

The factors associated with CS are age, parity, multiple pregnancy, maternal weight gain, and birth weight (Lin & Xirasagar, 2004; Qazi *et al*., 2013). Including these factors, the CS is justified under certain circumstances, such as cephalo pelvic disproportion and contracted pelvis; dystocia due to soft parts; inadequate uterine forces, antepartum haemorrhage, pre-eclamptic toxaemia, eclampsia; foetal distress and prolapse of the cord, malpresentation; maternal distresses such as heart problems, bad obstetric history, habitual intrauterine death of the foetus and elderly primigravida.

Perception about CS

Meanwhile, disease, deformity and death are terms usually employed to describe the experiences of a vast majority of sub-Saharan African women during pregnancy and birthing (Brookman, Amissah & Mayo, 2004). Similarly, the majority of African women are often viewed as being at high risk of infections, injury and death during pregnancy and the periods surrounding it (Izugbara & Ukwayi, 2007). Among women in developing countries, CS is still being perceived as a ‘curse’ of an unfaithful woman. Adeoye and Kalu (2011) further assert that caesarean section is seen among weak women. In addition, CS is surrounded with suspicion, aversion, misconception, fear, guilt, misery and anger among the women of South Western Nigeria (Adeoye & Kalu, 2011).

Knowledge of CS

This knowledge can be obtained through health education, electronic media, prints and health education programmes.

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Cultural Beliefs

Mboho (2013) opined that CS appeared to have various meanings for the respondents. Although the women agreed that it was a procedure done in hospital to save the lives of women and that of their babies, the majority of them believed that it could be avoided if the individual was conscious of the activities of the 'wicked people'. Culturally, CS was seen as a 'curse' and a 'failure of womanhood'. This view was well articulated during focus group discussions with mothers-in-law and during individual interviews with women of childbearing age.

Cost of CS

Maternal request CS births are associated with increased direct cost when compared to vaginal births. A CS delivery in 2006 without complications cost $6,946 compared to vaginal delivery without complications ($4,490) in a busy tertiary hospital at Stanford, CA (Druzin & El-Sayed, 2011). Figures by Declercq and colleagues (2007) were slightly different overall, but the trend was the same with a planned CS costing $4,372 versus $2,487 for a vaginal delivery. This data was based on 470,857 birth certificates in Massachusetts. If complications arise after the CS, cost is increased further. Costs in subsequent pregnancies rise as placenta implantation complications occur (Druzin & El-Sayed, 2011). The increased length of hospital stay that occurs with maternal request CS also increases cost. The average length of hospital stay for a mother after a CS is 4.3 days versus 2.4 days for a vaginal delivery (Declercq, 2012). Hospitals report higher occupancy rates, which leads to reduced patient satisfaction (Druzin & El-Sayed, 2011).

Cost is an important factor in our region where the majority of the hospitals operate the policy of pay-as-you-go for health care services (Bako *et al*., 2014) . The preference for CS among women of high socioeconomic class has earlier been reported in Turkey (Buyukbayrak *et al*., 2010) and Australia (Roberts *et al*., 2012). The cost of CS in one of the health facilities used for this study is

The Adaptation Model

The Adaptation Model developed by Sister Callista Roy was selected for the conceptual framework to guide the study of maternal adjustment experienced during childbirth. The Roy Adaptation Model (Roy & Andrews, 2011) conceptualises the individual as an adaptive system interacting with constantly changing environmental stimuli. The environmental stimuli are classified as focal, contextual, and residual. Focal stimuli are defined as those immediately confronting the individual that demands attention. Contextual stimuli are all other stimuli present that affect the person's behaviour or context of the situation. The residual stimuli are vague, nonspecific stimuli such as beliefs, attitudes, experiences, and expectations that influence the individual's response to the focal stimulus. Once the effects of residual stimuli are validated, they become contextual stimuli. The birth experience provides a mother with multiple stimuli to which she must adapt. For the purposes of the present study, the focal stimulus includes the physical and emotional demands of the childbirth experience, whether it be a vaginal or caesarean birth.

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METHODOLOGY

The study adopted a cross-sectional design. This design is concerned with the present and tells how people feel or react to phenomena under investigation. The study was conducted in Ebute Metta, Mainland Local Government Area of Lagos State. The study population consists of women of childbearing age (18-45 years of age). Participants include pregnant women attending antenatal clinic while women on admission on the gynaecology ward are excluded from this study. The sample size was 138, made up of women attending antenatal clinics within the sampling area in Ebute Metta, Lagos.

Purposive and quota sampling technique were used to select the health facilities and respondents. They are Federal Medical Centre, Ebute Metta (40 respondents), State Health Centre, Ebute Metta (30 respondents), Primary Health Care Centre (20 respondents), St. Anne Infirmary for Women, Dawodu Lane, Ebute-Metta (17 respondents), and Redeemed Christian Church of God Maternity Centre Ebute Metta (31 respondents). Self-structured questionnaire was used to collect data.

Descriptive data were used to calculate the means while Pearson's Chi-square analysis with the aid of Statistical Package for Social Sciences (SPSS Version 21.0) was used for testing the formulated hypotheses at 0.05 and 0.01 significance level. Ethical consideration of the respondents was considered.

Table 4.1: Demographic Data of Respondents

Age	**Frequency**	**Percentage**	**Mean**	**Std. Dev.**
18-25 years	16	12.4%		
26-33 years	57	44.2%		
34-41 years	38	29.5%	(2.80) 37.5 years	1.182
42 years and above	18	14.0%		
Total	**129**	**100%**		
Marital Status	**Frequency**	**Percentage**		
Single	5	3.9%		
Married	121	93.8%	(2.01) Married	0.385
Widow	1	0.8%		
Divorced	1	0.8%		
Separated	1	0.8%		
Total	**129**	**100%**		
Educational Qualification	**Frequency**	**Percentage**		
No formal education	2	1.6%		
Primary	1	0.8%		
Secondary	27	20.9%		
Tertiary	99	76.7%	(3.73) Tertiary	0.556
Total	**129**	**100%**		
Religion	**Frequency**	**Percentage**		
Christianity	104	80.6%	(1.20) Christianity	0.422
Islam	24	18.6%		
Others	1	0.8%		
Total	**129**	**100%**		

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Occupation	**Frequency**	**Percentage**		
Civil Servant	41	31.8%	(2.74) Civil Servant	1.738
Trader	24	18.6%		
Entrepreneur	36	27.9%		
Apprentice	2	1.6%		
Student	10	7.8%		
Housewife	13	10.1%		
Others	3	2.3%		
Total	**129**	**100%**		
No. of Children	**Frequency**	**Percentage**		
None	16	12.4%		
1 Child	41	31.85%		
2 Children	28	21.7%	(2.84) 2 Children	1.944
3 Children	25	19.4%		
4 Children	14	10.9%		
5 Children	4	3.1%		
6 Children and above	1	0.8%		
Total	**129**	**100%**		

Source: Field Survey, 2017.

Table 4.2: Perception of Respondents towards CS

S/N	**Perception**	**Category**	**Frequency**	**Percentage**	**Mean**	**SD**
1.	Women who deliver their baby by caesarean section miss an important life experience.	Good Perception	41	31.8%	2.80	1.071
		Fair Perception	43	33.3%		
		Poor Perception	45	34.9%		
2.	Mothers regains her health status sooner after vaginal delivery than caesarean section.	Good Perception	46	35.7%	3.13	0.794
		Fair Perception	58	45%		
		Poor Perception	25	19.4%		
3.	Complications could lead to a prolonged stay in hospital.	Good Perception	62	48.1%	3.36	0.739
		Fair Perception	57	44.2%		
		Poor Perception	10	7.8%		
4.	Caesarean section is preferable as against pain of labour and	Good Perception	27	20.9%	2.37	0.977
		Fair Perception	46	35.7%		

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	vaginal delivery which is unpleasant.	Poor Perception	56	43.4%		
5.	A woman can achieve vaginal birth after caesarean section.	Good Perception	42	32.6%	3.12	0.817
		Fair Perception	67	51.9%		
		Poor Perception	20	15.6%		
6.	Babies born by caesarean section are healthier than those delivered by vaginal delivery.	Good Perception	60	46.5%	3.27	0.817
		Fair Perception	49	38.0%		
		Poor Perception	20	15.6%		
7	Caesarean section affects early bonding between mother and child.	Good Perception	44	34.1%	2.12	1.008
		Fair Perception	39	30.2%		
		Poor Perception	46	35.7%		

Source: Field Survey, 2017.

Table 4.3: Knowledge of Respondents about CS

S/N	Knowledge	Category	Frequency	Percentage	Mean	SD
1.	Have you heard about CS as a method of delivery?	High Knowledge	122	94.6%	0.95	0.227
		Moderate Knowledge	-	-		
		Low Knowledge	7	5.4%		
2.	CS is as safe as vaginal birth.	High Knowledge	95	73.6%	0.74	0.442
		Moderate Knowledge	17	13.2%		
		Low Knowledge	17	13.2%		
3.	If CS is compared to vaginal birth it prevents bladder problems (such as urinary frequency, urgency or loss of urine) in the future.	High Knowledge	68	52.7%	0.47	0.501
		Moderate Knowledge	-	-		
		Low Knowledge	61	47.3%		
4.	CS means the following:	High Knowledge	98	76%	0.76	0.429
		Moderate Knowledge	-	-		

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	Delivery through the vagina without surgical incision.	Low Knowledge	31	24%		
5.	Delivery through an incision on the abdomen.	High Knowledge	108	83.7%	0.84	0.371
		Moderate Knowledge	-	-		
		Low Knowledge	21	16.3%		
6.	Delivery by giving injection through the vagina.	High Knowledge	97	75.2%	0.25	0.434
		Moderate Knowledge	16	12.4%		
		Low Knowledge	16	12.4%		
7.	CS is done to: Save the life of the baby.	High Knowledge	100	77.5%	0.78	0.419
		Moderate Knowledge	-	-		
		Low Knowledge	29	22.5%		
8.	CS is done to: Safe the life of the mother.	High Knowledge	96	74.4%	0.74	0.438
		Moderate Knowledge	-	-		
		Low Knowledge	33	25.6%		
9.	Safe the life of both mother and baby.	High Knowledge	129	100%	1.00	0.000
		Moderate Knowledge	-	-		
		Low Knowledge	-	-		

Source: Field Survey, 2017.

Table 4.4: Cultural Beliefs of Respondents towards CS

	Cultural Beliefs	**Agree**		**Disagree**	
		Frequency	**Percentage**	**Frequency**	**Percentage**
19.	Religion frowns at CS	32	(18.6%)	105	(81.4%)
20.	Culture perceives CS as evil (in the south)	30	(23.2%)	99	(76.8%)
21.	Family stigmatise a woman that has undergone CS as a 'weak' person	31	(24.1%)	98	(76.0%)

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22.	Culture perceives CS as a repercussion to infidelity.	28	(21.7%)	101	(78.3%)
23.	Community members make mockery of a woman who has undergone CS.	30	(23.3%)	99	(76.8%)

Source: Field Survey, 2017.

Table 4.5: Responses of Respondents on Cost of CS

	Cost	**Agree**		**Disagree**	
		Frequency	**Percentage**	**Frequency**	**Percentage**
24.	Cost implication affects acceptance of CS.	112	(86.8%)	17	(13.2%)
25.	CS is preferable in the absence of economic problems	58	(44.0%)	71	(56.0%)
26.	CS costs more than vaginal delivery	121	(93.8%)	8	(6.2%)
27.	Additional cost is attached to CS.	116	(89.9%)	13	(10.1%)

Source: Field Survey, 2017.

Table 4.6: Experience of Respondents towards CS

	Experience of Caesarean Section	**Agree**		**Disagree**	
		Frequency	**Percentage**	**Frequency**	**Percentage**
28.	I have experienced CS as a safe method of delivery.	64	(49.6%)	65	(50.4%)
29.	I have never experienced CS	83	(64.4%)	46	(35.7%)
30.	Children/child delivered through CS usually have no birth complications	45	(34.9%)	84	(65.1%)

Source: Field Survey, 2017.

Table 4.7: Acceptance of CS

	Acceptance of Caesarean Section	**Agree**		**Disagree**	
		Frequency	**Percentage**	**Frequency**	**Percentage**
31.	I will only accept CS to save my life or that of my baby.	123	(95.3%)	6	(4.7%)
32.	I will prefer CS to vaginal delivery in order to prevent labour pain experience.	39	(30.3%)	90	(69.7%)

Source: Field Survey, 2017.

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DISCUSSION OF FINDINGS

Findings in table 4.2 revealed that the majority of the (65.1%) respondents agree that women who undergo CS do not miss an important life experience. Majority of the respondents (80.7%) agree that mothers regain their health status sooner after vaginal delivery compared to delivery by CS. This is as a result of the need to observe the mother for any significant change/complication and the need for the mother and/or child to be duly certified by the doctor to go home. Majority of the respondents (92.3%) perceive that complications could arise during or after CS and it can lead to a prolonged stay in hospital. Majority of the respondents (56.6%) would prefer having their baby by vaginal delivery and bear the pain of vaginal delivery than to have a CS. Women will prefer to have vaginal delivery at all costs except for a situation where CS is the best option to save the life of the mother and child. Majority of the respondents (64.3%) do not perceive CS to affect early bonding between mother and child.

Findings in table 4.3 shows that (94.6%) of the respondent have heard of CS as a method of delivery but do not know the meaning of CS and its benefits to both mother and child, out of which (73.6%) of the respondent said CS is as safe as vaginal birth. (77.5%) and (74.4%) of the respondents ticked that CS is done to save the life of the mother and infant respectively. (100%) of the respondents ticked that CS is done to save both the life of the mother and child. In most cases, CS is done to save the life of the mother and child. Statistically, table 4.8 showed that knowledge of CS will significantly affect acceptance of CS among women of childbearing age with X^2= 65.163; df=22; $p<0.05$; 0.05 level of significance**.** This finding is in line with the findings of Bako et al. (2014), Habib *et al*. (2011), and Saoji *et al.* (2011) where the level of knowledge and education of the respondent is a factor affecting the acceptance of CS.

Cultural beliefs were found to affect the acceptance of CS among women of childbearing age. Finding in table 4.4 showed that some of the respondents (18.6%) agree that family members stigmatise a woman that has undergone CS as a weak person. 21.7% of the respondents' culture perceives CS as a repercussion to infidelity. 23.3% of the respondents agree that their community members make mockery of a woman who has undergone CS. Cultural belief will significantly affect acceptance of CS among women of childbearing age. Statistically, cultural belief will significantly affect acceptance of CS among women of childbearing age with X^2= 88.271; df= 43; $p<0.05$. This finding is similar to that of Mboho (2013) where cultural belief is a factor affecting the acceptance of CS in Akwa-Ibom State, Nigeria.

Results showed in table 4.5 that 86.8% of the respondents agree that cost implication affects acceptance of CS. 93.8% of the respondents agree that CS is more expensive than vaginal delivery. Majority of the respondents 89.9% agree that additional cost is attached to CS. This implies that cost of CS is also a factor affecting its acceptance as about 30.3% of the respondents will prefer CS as a method of delivery. Findings similar to the preference for CS among women of high socioeconomic class has earlier been reported in Turkey (Buyukbayrak *et al*., 2010) and Australia (Roberts *et al*., 2012).

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IMPLICATION TO RESEARCH AND PRACTICE

Findings revealed that:

- Knowledge of CS will significantly affect acceptance of CS among women of Childbearing age**.**
- Cultural belief will significantly affect acceptance of CS among women of Childbearing age.

CONCLUSION

Most of the women are educated but not well informed about CS. The potential demand for CS was low and the majority of women preferred vaginal delivery. However, most are still in favour of CS if it is necessary to protect their lives or that of their infants. It is therefore inferred from this study that the majority of women that undergo caesarean section do not like this method of delivery, they probably opted for it because it is the only available option.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

1. The management of hospitals should take health education of pregnant women very seriously and information, education and counselling should target women in both group discussions and personal counselling sections.
2. The hospital management should have enough nursing personnel in the ante-natal clinic who will engage in group or one-on-one counselling sessions to educate women on CS and its importance in reducing maternal, infantile morbidity and mortality.
3. Nurses should organise periodic workshops and seminars on appropriate counselling techniques for nurse-midwives so as to develop excellent interpersonal and counselling skills that will help improve nurse-patient communication.
4. Government should help subsidise the cost of CS delivery and pay inducement for pregnant women who attend antenatal clinics to encourage planned regular visits in government hospitals across health facilities that carry out CS operation. This creates opportunities for health education for pregnant women in terms of measures to prevent factors that may be prone to CS complication which may affect the health of the mother or/and child and sensitise them on the need to accept it as delivery approach when need be.

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FURTHER RESEARCH

Further study should be done among women that had had previous experience of the two methods of birth. This study was conducted among women attending antenatal clinic in tertiary, secondary, primary and private health care facilities, however further study could be done in multi-state so that the result will be generalised, and better comparison can be made across religion and ethnicity.

Table 1: The relationship between Knowledge of CS and Acceptance of CS.

	Knowledge of CS affecting acceptance
Chi-Square	65.163
Df	22
Asymptotic Significance	0.000

Table 2: The relationship between Cultural Belief of CS and Acceptance of CS.

	Cultural beliefs affecting Acceptance of CS
Chi-Square	88.271
Df	43
Asymptotic. Sig	0.000

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