KNOWLEDGE AND ATTITUDE OF MALE PARTNERS TOWARDS CAESAREAN SECTION IN IBADAN NORTH LOCAL GOVERNMENT AREA, IBADAN, OYO STATE

BY

Favour OBOIJAGBE
BSC HEALTH EDUCATION (UNIBEN)
MATRIC. NO: 210581

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CERTIFICATION

I hereby certify that this study was carried out by Favour, OBOIJAGBE in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.

SUPERVISOR

Dr. Musibau A. Titiloye

B.Sc. (UNNAB), MPH, PhD (IBADAN), Post Doc (UKZN)

Senior lecturer

Department of Health Promotion and Education,

Faculty of Public Health, College of Medicine,

University of Ibadan

DEDICATION

This research study is dedicated to the almighty God for the grace to start and complete this project.

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I am grateful to the almighty God for his grace throughout the course of this research in fulfillment of my master's program. I thank my parents, Mr. and Mrs. A. Oboijagbe for supporting me through the course of this program, morally, financially and otherwise. I thank my friends for their constant encouragement

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ABSTRACT

The under utilisation of caesarean section poses a major problem in developing countries. Acceptance and refusal of caesarean section are both major indicators for maternal and newborn mortality and morbidity. Prevalence of caesarean section is low in Nigeria pointing to a need in the delivery of the procedure. To better understand the reason why women do or do not utilise caesarean sections, their male partners have to be factored in especially in sub-Saharan Africa amongst which Nigeria is a country. Husbands in the traditional Nigerian cultures have authority over their wives and the decisions they make. This study is designed to investigate the knowledge and attitude of male partners towards caesarean section in Ibadan North Local Government Area of Oyo State.

This study was a cross-sectional study design and 323 male partners were selected from 12 communities in the Local Government Area. A Multi-stage sampling technique comprising of simple random sampling and systematic sampling was applied to select the study participants. A structured interviewer-administered questionnaire was used to elicit information on the knowledge and attitude of male partners toward caesarean section. The knowledge of the respondents was assessed using an 18 point scale and scores were categorised as poor (0-6), fair (6-12), and good (>12). The attitude of respondents was also assessed using a 10-point scale and the scores were categorised as negative (≤5) and positive (>5). The data were analysed using descriptive statistics, Chi-square, Fisher's exact test and regression at $p \leq 0.05$ level of significance.

Mean age of the respondents was 44.8±11.4 years. The largest percentage by age was men from 40 to 60 years of age (44.0%). The predominant ethnic group was the Yoruba ethnic group (91.0%). Most of the respondents were married (91.3%) and a few others were single (5.3%), divorced (0.9%) or separated (8%) The study shows that the highest percentage of those with a positive attitude (51.3%) had tertiary education. Among the 47.7% respondents that had tertiary education, 77.9% had good knowledge about caesarean section. Most of the respondents had an average monthly income below 50,000 Naira (42.7%), while the highest number of respondents with good knowledge (88.9%) were among those who earn above

150,000 naira (5.6%). Majority of the respondents were self-employed (36.2%). Over 95% of the respondents were aware of caesarean section. The overall knowledge about caesarean section was majorly fair (57.1%) with 42.5% having good knowledge. Despite their knowledge, the attitude of the respondents was negative (54.5%). The result of the chi-square test indicates that there is a significant association between respondent's average monthly income and their attitude towards caesarean section.

Respondents had fair knowledge of caesarean section but this did not influence their attitude towards the procedure. Rather, what influenced them most were the cost of the procedure and fear of death or complications. Male involvement during pregnancy, delivery and afterwards is important to ensure male partners have the right attitude towards caesarean section and they are equipped to make decisions that will benefit the health of the woman.

Keywords: Caesarean section, male partners, attitude, knowledge
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TABLE OF CONTENTS

Content **Page**

Title page……………………………………………………………………………i
Certification ……………………………………………………………………………ii
Dedication……………………………………………………………………………...iii
Acknowledgement………………………………………………………………………iv
Abstract ……………………………………………………………………………...v
Table of contents……………………………………………………………………… vi
Tables……………………………………………………………………………………vii
Figures…………………………………………………………………………………viii
List of Appendices………………………………………………………………………ix
Glossary of abbreviations………………………………………………………………..x

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study……………………………………………………………..1
1.2 Statement of the Problem……………………………………………………………...2
1.3 Justification……………………………………………………………………………..5
1.4 Research Questions…………………………………………………………………..6
1.5 Broad objectives of the study………………………………………………………...6
1.6 Specific objectives of the study……………………………………………………...6
1.7 Hypothesis……………………………………………………………………………...7
1.8 Operational definition of terms……………………………………………………...7

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction…………………………………………………………………………....8
2.2 Types of caesarean section ……………………………………………………...……9
2.3 Prevalence of caesarean section ………………………………………………………..10
2.4 Maternal mortality in Nigeria…………………………………………………………..11
2.5 Medically indicated reasons for caesarean section…………………………………..11
2.6 General attitude towards caesarean section…………………………………………12

2.7 Male partners attitude on the choice of caesarean section……..13
2.8 Factors that affect male partners attitude towards caesarean section……..15
2.9 Theoretical framework……..……..18
2.9.1 Application of the framework…….……21

CHAPTER THREE: METHODOLOGY

3.1 Study design……22
3.2 Study area ……22
3.3 Study population……..23
3.4 Inclusion criteria……..23
3.5 Exclusion criteria……24
3.6 Sample size determination……...24
3.7 Sampling procedure and techniques……24
3.8 Instrument for data collection……25
3.9 Validity……25
3.9.1Reliability……26
3.9.2 Data collection procedure……26
3.9.3 Data management and analysis……26
3.9.4 Ethical consideration……26

CHAPTER FOUR: RESULTS

4.1 Respondents' Sociodemographic Characteristics……..28
4.2 Respondents' awareness of caesarean section……...31
4.3 Respondents' knowledge of caesarean section……..31
4.4 Respondents' attitude towards caesarean section ……35
4.5Factors affecting respondents' attitude towards caesarean section……38
4.6Test of Hypothesis……..40
4.7 Regression analysis showing the correlation between factors and attitude of respondents towards caesarean sections……..……50

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1.1 Respondents' Sociodemographic characteristics…..…….55

5.1.2 Respondents' awareness of caesarean section ……...55

5.1.3 Respondents' knowledge on caesarean section ……56

5.1.4 Respondents' attitude towards caesarean section.…….57

5.1.5 Factors affecting respondents' attitude towards caesarean section……58

5.1.6 Implications to health promotion and education……59

5.2 conclusions……60

5.3 Recommendations……..60

REFERENCES……..62

LIST OF TABLES

Page

4.1a Sociodemographic information of respondents……29
4.1b Sociodemographic information of respondents……30
4.2 Respondents' knowledge of caesarean section……33
4.3 Respondents' overall knowledge score……34
4.4 Respondents' attitude to Caesarean section……36
4.5 Overall attitude score of respondents……37
4.6 Factors affecting respondents' attitude towards caesarean section……39
4.7a Sociodemographic information of respondents relating to their level of knowledge....41
4.7b Sociodemographic information of respondents relating to their level of knowledge…42
4.8a Sociodemographic information of respondents relating to their attitude……44
4.8b Sociodemographic information of respondents relating to their attitude……45
4.9a Socio-cultural factors relating to respondents attitude……47
4.9b Psychological factors relating to respondents attitude……48
4.9c Religious factors relating to respondents attitude……49
4.9.1a Regression analysis of socio-cultural factors……52
4.9.1b Regression analysis of psychological factors……53
4.9.1c Regression analysis of religious factors……54

LIST OF FIGURES

Page

Figure 1 Spot map of caesarean section rates around the world……..4

Figure 2 Theoretical framework and its application to the study……19

LIST OF APPENDICES

Page

Appendix 1: Informed consent ……..69

Appendix 2: Questionnaire (English Version)……...……72

Appendix 3: Questionnaire (Yoruba Version)……..……77

Appendix 4: Ethical Approval from the Oyo State Ministry of Health…….……82

GLOSSARY OF ABBREVIATIONS

CS	-	Caesarean section
LGA	-	Local Government Area
IBNLGA	-	Ibadan North Local Government Area
WHO	-	World Health Organization
UNICEF	-	United Nations Children's Fund

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Caesarean section is an Obstetric surgery to deliver a child through an incision on a woman's abdomen. It has by far become the most common abdominal surgical procedure in the world. Despite this, caesarean section is a procedure that has not been fully accepted in most developing settings. In Nigeria, there is Underutilization of the service (Adewuyi, Auta, Khanal, Tapshak and Zhao, 2019). Nigeria has one of the highest rates (fourth highest) of maternal mortality and this is a disturbing fact considering that some of these deaths could be prevented through caesarean section (Omobolanle, Olowookere, Tolulope and Idowu, 2018). Instead, patients are often averse to caesarean section when in actual fact, it could save lives. Apart from the obvious lack of infrastructure and inequitable access to obstetric surgery (Adewuyi, 2019) in such developing settings, a range of other factors might explain better the reason for the low uptake of caesarean section. Stigmatization of caesarean section stems from the social and cultural non-acceptance of the procedure, decisions from significant others and fear of danger amongst others (BBC feature 2018).

As opposed to the underutilization in low income countries, the rate of caesarean section has increased worldwide significantly over the last decade. More caesarean section procedures are being performed in most developed countries for non-medical reasons and this situation has been termed 'unjustified' by scholars (Mukherjee, 2006). It has also increased rapidly in many OECD countries over the last 10 years with the average rate across countries going from 20% in 2010 to 27% in 2011 (OECD, 2013). Findings have shown that increase in first birth among older women and increase in multiple births (OECD, 2013) as well as improved anesthesia, availability of blood transfusion and antibiotics (Adewole and Zaman, 2018) are issues that have contributed significantly to the total increase in caesarean sections rates. Today, caesarean sections appear to be happening far more than is medically necessary (Wolf, 2018) in developed countries, even though the World Health Organization has contended that the optimal rate for caesarean sections should be between 10 to 15 percent of

births (WHO, 2015). While these findings are true of developed countries, other studies have found that there is still a great aversion to caesarean section in low-income settings such as Nigeria (Akinola, Fabamwo, Tayo and Rabiu, 2014)

Prevalence of caesarean section has increased worldwide without medical justification and due consideration of the risks it poses to the mothers and children born via caesarean section (Soto-Vega, 2015). Literature from 18 different countries shows a staggering prevalence of caesarean section compared with that stipulated by the World Health Organization with a mean of 45.2% of caesarean section worldwide (Soto-Vega, 2015). Still, amongst this global increase, Nigeria as a country stands out as having one of the lowest rates. Though, in Nigeria, there has been an increasing trend in the amount of caesarean section procedures performed with rates from 9.4% in the 1970s and 34.6% in 2018 (Ezeome, Ezugworie and Udealor, 2018). Still, rising indications insinuate that the rate of caesarean section is still not enough to meet the country's needs for the procedure (Okonofua, 2001).

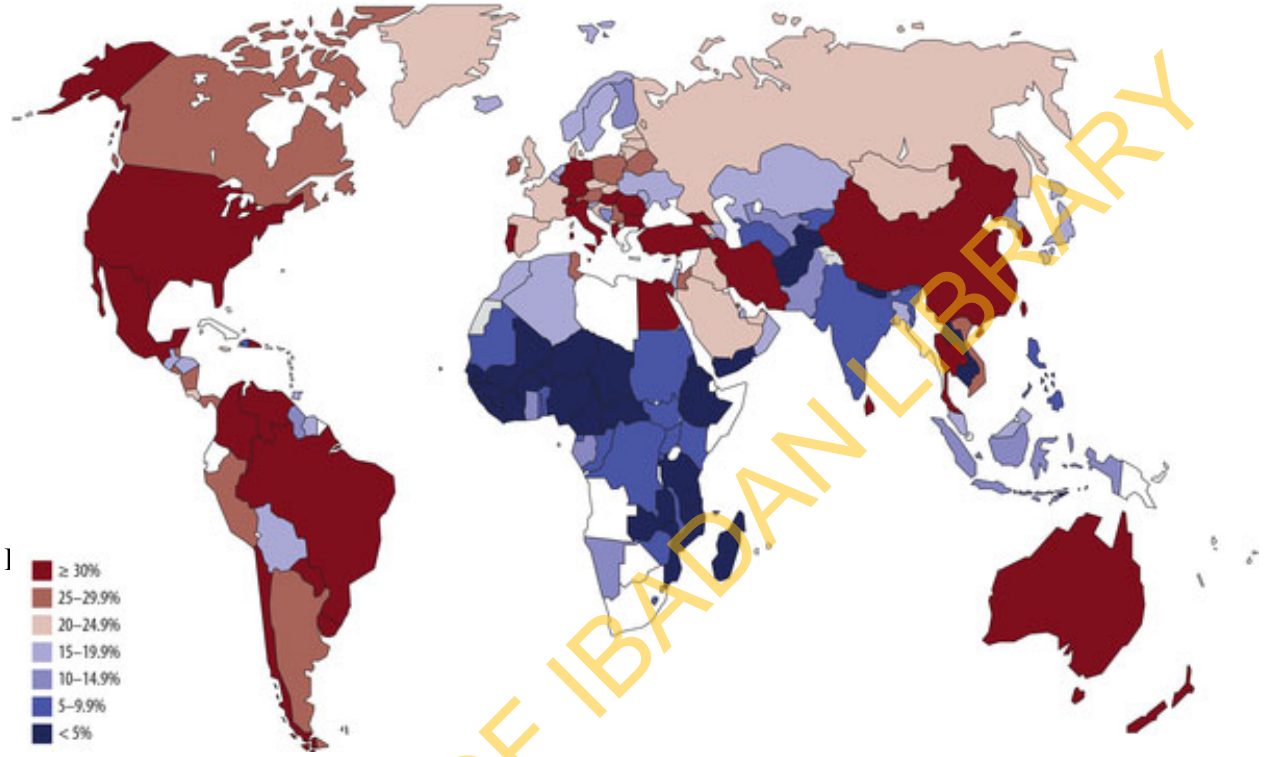
With a very high rate of maternal mortality (Olopade and Lawoyin, 2008), low uptake of caesarean section in different settings within the country pose a problem to the totality of the Nigerian health sector. According to a study conducted in a semi-urban setting in northwestern Nigeria, it was found that consent for caesarean section was delayed or not given at all when husbands or male partners were approached (Ashimi, Amole and Aliyu, 2013). Many predictive factors can be traced to be the reasons for this, amongst which is the male dominance in African societies. This is a society where the man is the head of the home and commands both respect and submissiveness. These gender power relations affect maternal health care in many ways (Bello, Olayemi, Ogunbode and Adekunle, 2011). There is a mix-up in the fact that while male participation in maternal reproductive health matters such as family planning, antenatal and mode of delivery is very minimal, yet they affect the decision making power of the woman in their societal designated roles as head of the home, partner and leaders due to their control over household resources and decision making in the home (Morgan, Tetui, Kananura, Kiracho and George, 2017).

1.2 Statement of Problem

The World Health Organization considers caesarean section rates of 10-15% to be acceptable within regions as the optimal range of caesarean sections for mother and child (WHO, 2015).

However, this is unjustified as access to safe caesarean section is still very low in sub-Saharan regions of Africa. A rate below 5% indicates that the population lacks access to proper health technologies for such a surgical procedure and indicates poor health systems in such a setting (Soto-Vega, 2015). More particularly within middle-income countries, inequities greatly influence both ends of the social scale, causing a very wide gap such that, people at the top of the social ladder, have more caesarean sections than is necessary while those at the bottom do not get enough to save the mother and the child (Victora and Barros, 2006).

Caesarean sections are about five times more prevalent among people at the top of the wealth and social ladder in low and middle-income countries (Gonzalez and Grant, 2019). There have been growing attentions to the low uptake of caesarean section in different settings and the problems that they point at (Althabe and Belizan, 2006). Some of which include, high rates of maternal mortality and a lacking health system. In a study of increasing trends of caesarean section in 150 countries, the data showed that Africa had the lowest rate of caesarean section (Betrán, Ye, Moller, Zhang, Gülmezoglu and Torloni, 2016). In Africa, there are major disparities. While southern Africa's rates of caesarean section are skyrocketing (Gonzalez and Grant, 2019), western Africa was rated as having the lowest percentage of caesarean births (less than 5%) and the lowest growth rate of caesarean deliveries (Betran et al, 2016). A closer look shows that caesarean deliveries in Nigeria are way below the benchmark stipulated by the WHO with an estimated 2% of births nationwide (NPC and ICF Macro, 2014).



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From figure 1.1 above, the low rate of caesarean section may pose a problem especially as it is particularly needed in developing countries where maternal mortality rates are high (Ezugwu, Iyoke, Iloghalu, Ugwu, Okeke and Ekwuazi, 2017). Various studies have shown that male partners are a deciding factor for the acceptance or refusal of caesarean section in Nigeria (Amiegheme, Adeyemo and Onasoga, 2016; Aziken, Omo-Aghoja and Okonofua, 2018; Chigbu and Iloabachie, 2007). In making decisions about the mode of childbirth, women are faced with many options, each with its associated risks and benefits. These decisions are often influenced one way or the other by other people i.e. family members, friends, spouse etc. while men in contemporary societies prefer to rely on the health system and allow the medical practitioners to make such decision as to the mode of delivery (Johanssen, Hildingsson and Fenwick, 2014).

Their counterparts in a typical African setting like Ibadan, in Nigeria, are different. The women consult their men when making certain important life decisions. This is due to the perceived male dominance in many of these societies (Tajuddin and Shamsuddin, 2015). The decisions made are often affected by attitudes towards the matter. It is therefore important to understand the father's attitudes towards caesarean section and the factors influencing them because they play an important role in reproductive decision making. Considering the above, there is still very little research that has been done about male partners including male partner's attitude towards caesarean section or decision making in childbirth as a whole (DeJoy, 2011; Johansson et al, 2014) thus there is a knowledge gap to be filled in this area.

1.3 Justification

A substantial increase in caesarean section rates will improve maternal and perinatal outcomes (Litorp, Myaga, Hussein, Johndotter, and Essen, 2015).A father's role in the birth of a child and all of the activities leading up to this cannot be overemphasized. The conception, gestation period, birth and upbringing of a child is the joint effort of the mother and father. Fathers and male partners involvement in pregnancy and childbirth improves health outcomes for the mother, the child and even the fathers themselves (Plantin, Karlson and Dykes, 2011).

In a study by Abushaika and Massah of the roles of fathers during childbirth, all of the newly delivered women who participated unanimously agreed that they felt encouraged, stronger and safer knowing that their male partners were present during labour. The male partners also agreed to this, affirming that it gives them a feeling that they are able to help (Abushaika and Massah, 2012).

In light of the above, male partner's knowledge and attitudes towards caesarean sections will greatly affect their participation in the birth process and decision making. Much study has not been hitherto done on the knowledge and attitudes of male partners towards caesarean section revealing a gap of knowledge in this area, thus the justification and reason for this study.

The findings from this study might inform interventions for increasing men's involvement in caesarean section and overall delivery decisions. This study also aims to break new grounds of knowledge by creating an understanding of male partner's knowledge and attitude towards caesarean sections in Ibadan North Local Government Area.

1.4 Research Questions

1. What is the level of knowledge of male partners on Caesarean Section in Ibadan North Local Government Area?
2. What is the prevailing attitude of male partners towards caesarean sections in Ibadan North Local Government Area?
3. What are the factors influencing male partner's attitude towards caesarean section in Ibadan North Local Government Area?

1.5 Broad Objectives

The broad objective of this study was to investigate male partner's knowledge and attitude towards caesarean section in Ibadan North Local Government Area

1.6 Specific Objectives

1. To assess the knowledge of male partners concerning caesarean section in Ibadan North Local Government Area

2. To determine the attitude of the male partners towards caesarean section in Ibadan North Local Government Area
3. To identify the factors influencing male partners' attitude towards caesarean section in Ibadan North Local Government Area

1.7 Hypotheses

1. There is no association between sociodemographic variables (age, income, religion e.t.c.) and male partners' knowledge of caesarean section
2. There is no association between sociodemographic variables and male partners' attitude of caesarean section
3. There is no association between factors and male partners' attitude towards caesarean section

1.8 Operational Definition of Terms

- **Male Partners:** All men, married or unmarried who have had at least one child in the last 10years or have had their partners or spouses pregnant at least once.
- **Caesarean Section**: A caesarean section is a surgical procedure to birth a child, in which an incision is made on the mother's abdomen and on the uterus in order for the fetus to be manually taken out of the womb

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The history of Caesarean section is as far back as ancient Roman times. The beginning of the practice is not known and the initial motives of cutting a woman open to birth a baby were not documented. Some scholars believe that a relative of Julius Caesar whom he was named after was given birth to through a caesarean(Sewell,2000). However, the origin of caesarean sections is still debatable. Historically, caesarean sections (often called C-sections now), were done to save babies rather than their mothers and only by chance did mothers actually live through it due to infections and bleeding. Most times, it was to save the baby from a mother who had died during childbirth (Aabakke, 2014). Performing a caesarean section in those days mean resigning to a fate that the mother would most probably die and anything should be done to save the unborn child, thus, the high rate of maternal mortality (Aziken et al., 2007).

The first documented case of a mother surviving a Caesarean section was supposedly in the 1580s in Switzerland where a pig gelder performed the operation on his wife who was having difficulty in giving birth. The woman survived and went on to have five other vaginal births and lived to 77 years of age (Dongen, 2009).It was said that her male partner used his knowledge of animal male partnerry but since this story was recorded 82 years later, historians doubt its accuracy.

Gradually Maternal mortality reduced very drastically, especially in the last quarter of the 19th century owing to newly discovered sciences and techniques such as closing the uterine wound, asepsis, anti-sepsis and the choice of elective caesarean section (Dongen, 2009).In recent times, better healthcare quality has also led to an increase in caesarean section (Adewole and Zaman, 2018).

A caesarean section is a surgical procedure to birth a child, in which an incision is made on the mother's abdomen and on the uterus in order for the fetus to be manually taken out of the womb (Diana, 2016). A caesarean section may be planned in some situations where it

becomes evident during pregnancy that the surgery will be required or it may be an emergency. A caesarean section is usually required when a vaginal delivery will put the mother and the child at risk. The incisions on the abdomen are done based on the shape of the mother's pelvis or history of a previous caesarean section. Caesarean sections usually take a longer recovery time than vaginal deliveries. It is one of the oldest and most common surgical procedures in obstetrics and gynaecology (Abalos, 2015).

2.2Types of Caesarean Sections

Caesarean sections are often grouped into elective and emergency C-sections based on the timing and reason for the procedure. Both elective and emergency caesarean sections have related complications with the mother and the newborn. However, emergency caesarean sections have more complications than elective caesarean sections (Diana et al., 2006).

2.2.1 Elective caesarean section: This is also called a planned caesarean section. It is one that has been predetermined during pregnancy due to some complications that become evident as the pregnancy progresses. Elective caesarean section may also be one that has not been medically indicated in that it is done on maternal request (Balihe, Hayes and Fuddy, 2010). Planned caesarean section agreed upon by the mother and her physician due to predetermined issues forms diagnosis that might affect the health of the mother and child. Such issues include breech baby, placenta previa, health issues in the mother, number of babies to be born, other birth complications or a previous caesarean section (Choudhary, Patell and Sulieman, 2018). An elective caesarean section allows the parents to be able to prepare for their unborn child. Some have argued that it also helps the mother to have her baby on a particular date of interest although this selection of birth date is more of a social issue. In elective caesareans section, a date is set by the prospective parents and their physician for the child to be born. The mother is not caught unawares by labour pains, she goes to the hospital at the appointed time and the child is duly delivered

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2.2.2 Emergency caesarean sections: Emergency caesarean sections are performed as an urgent alternative to labour when the complications of labour and pregnancy need quick intervention due to various reasons such as fetal distress, prolonged obstructed labour, severe

preeclampsia and a ruptured uterus (Diana, 2016). Although lifesaving, emergency C-section has been found to increase maternal and infant risks. Usually, the need for a first time caesarean section becomes obvious during labour due to unforeseen complications that make the caesarean section safer than normal delivery (Amiegheme, Adeyemo and Onasoga, 2016). Studies have shown that a good number of emergency caesarean births were booked as elective caesarean sections. But due to the aversion of caesarean section in most African societies, the mother and family may be in denial until labour starts and danger lurks. At this time, an emergency caesarean section is needed to save the lives of the mother and the child.

2.3 Prevalence of caesarean section

Global disparities abound such that there have been a worldwide rise in caesarean section (CS) rates (Ashimi, Amole and Aliyu, 2013) in a way that it has become a cause of considerable debate due to potential maternal and perinatal risks, cost issues, burden on the health system and inequity in access stemming from the procedure (Torloni, Souza, Betran, and Allen, 2011). However, this is not the case for low-income countries as there seem to exist a double standard such that, while caesarean section rates may be high is developed settings, it is still very low in underdeveloped settings (Ashimi et al., 2013).

In Nigeria, the rate of caesarean section varies from centre to centre as different studies have reported various rates with 15.8% in Jos (Mutihir, Daru and Ujah, 2005), 20.3% in Birnin-Kebbi (Nwobodo and Wara, 2004), in Sokoto, the rate was 9.9% (Nwobodo, Isah and Panti, 2011).and 10.5% in a study done in Makurdi (Swende, Agida and Jogo, 2007). However, there is no substantial increase in the population-based rate of caesarean section

A cursory look at the Nigeria Demographic and Health Survey (NDHS) reveals that there was no indicator for the caesarean section rates in the last demographic health survey conducted in 2018 (NPC and ICF Macro, 2018). Further study into the demographic and health survey of 2013 showed that caesarean section rates were at 2% as at the time of compiling the survey findings. This is far below the optimum rates of 10% as specified by the World Health Organization (WHO, 2014). It is has become a major public health issue because the population-based caesarean section rate is a process indicator for measuring progress in maternal health (Begum, Raman, Nababan, Hoque, Khan and Anwar, 2007)

This is a cause for growing concerns in developing countries (Eifediyi, Isabu, Akhimiona and Affusim 2015) as low rates of caesarean section is an indicator for high maternal mortality and morbidity.

2.4 Maternal Mortality in Nigeria

According to the WHO, maternal mortality is very high with a whopping 94 percent of all maternal deaths happen in low and middle-income countries and most of them could have been prevented (WHO, 2019). According to the reports, the highest rates of maternal mortality that have been reported are from settings where inequities in access to health care services abound(WHO, 2019). A good number of these deaths are as a result of complications during pregnancy. These complications can be resolved by caesarean section. Maternal mortality and morbidity rates in Nigeria have remained one of the highest rates worldwide and makes up about 14% of the world's maternal mortality burden (Udobang, 2018). According to UNICEF estimates, In Nigeria, maternal mortality is as high as 917 deaths per 100000 live births (UNICEF, 2019). The risk of dying during pregnancy and childbirth among Nigerian women is 100 times greater than the risk of dying among women in developed countries (Odimegwu, Adewuyi, Odebiyi, Aina, Adesina, Olatubara and Eniola, 2005). Ensuring access to caesarean section is one of the essential strategies for meeting the sustainable development goal 3 to reduce the maternal mortality rate to less than 70 per 100000 live births.(UNICEF, 2019)

2.5 Medically Indicated Reasons for Caesarean Section

The rate of caesarean section has become a pressing issue of concern over the years, especially those without medical justification and due consideration of the risks it poses to mother and the child born through caesarean section. A woman's reasons for choosing caesarean sections may include, fear of pain during labour, preservation of coital function, social acceptance or male partner's decision. However, these reasons may not be enough justification for a caesarean section. Caesarean sections performed on non-medical indications in low-resource settings can also result in higher maternal risks than vaginal birth (Souza et al., 2010)

Unnecessary caesarean section may have negative effects on maternal, neonatal and infant morbidity and mortality. Also, the higher cost of caesarean sections as compared to vaginal delivery may cause very huge health expenses for families and individuals, in a way that the poor may not have ready access to a caesarean section when they need it (Ajeet et al, 2011) and also put additional pressure upon overburdened health systems especially in low and middle-income countries. Remarkably, non-medically indicated caesarean sections constitute a large proportion of the total caesarean sections performed annually (Khan et al, 2012) increasing the global burden of excess caesarean sections. The increasing caesarean section rate calls for monitoring of causes of all caesarean sections performed.

Medical indications from maternal complications may include, maternal distress, eclampsia, previous births by caesarean section, cases of asthma, psychological disorder, Rh-negative mother. While those from the fetus may include, placenta previa, multiple babies, breech baby, overweight baby, prolonged labour etc(Begum et al., 2017, Kaplanoglu et al., 2015).
This begs for the need for adequate and proper information to be provided to pregnant women and expectant mothers during antenatal on the modes of delivery and their indications, the advantages and consequences to enable them to make informed decision early as studies have shown that elective caesarean section has fewer complications than emergency caesarean section (Adewole and Zaman, 2018).

2.6 General Attitude towards Caesarean Section

As stated in the above paragraph, the increase in the rate of caesarean section is multi factorial as many factors lead directly or indirectly to the decisions pregnant women take about the mode of delivery preferred (Balmur and Guthi., 2017). These factors underlay the attitude they have of caesarean section, thus influencing their attitudes towards the procedure. According to Ezeome et al (2018) in his article on Beliefs, Attitudes, and Views of Pregnant Women about Cesarean Section and Reproductive Decision making in a Specialist Health Facility in Enugu, Southeast Nigeria, women in developing countries saw caesarean section as not only abnormal but also a lack of proof of womanhood.
In another study by Amiegheme et al (2016,) 76% of the participants considered it dangerous while 63% were unaware that a vaginal birth is still possible after a caesarean section

revealing that their knowledge about caesarean section is negatively low, while 79% of the participants feared death from caesarean section, 82% would not accept caesarean section because of the family preference for vaginal birth. However, the majority of the women would agree to a caesarean section to save the baby's life. According to the data, 60% of the participants also indicated that they would not opt for a caesarean section citing its cost as a hindrance to the proper utilization of the procedure in southern Nigeria (Amiegheme et al, 2016).

These studies agree with that of Ajeet et al. (2011) whose finding implied that most of the women are not well informed about caesarean sections. In his study, the demand for caesarean section was quite low and most of the women who participated preferred vaginal delivery. Thus, women's preferences are unlikely to be the most significant factor driving the high caesarean rates. However, most are still in favour of caesarean section if it is necessary to protect their health or that of their infant. Many women also believe that caesarean section is associated with maternal death (Litorp et al, 2015). There is low acceptance of caesarean section by women in southern Nigeria. Previous experience, such as previous stillbirth or neonatal death, and previous caesarean section influence the level of acceptance of caesarean section among Nigerian women.

2.7 Male Partners' Attitudes on the Choice of Caesarean Sections

The role of male partners in maternal health when contemplating health programs and especially in underdeveloped and developing countries (Lewis, Lee, and Simkhada, 2015). This is also more often than not an under-researched topic. Male involvement is an important strategy for improving birth preparedness because of patriarchy which makes the male in control of women's access to and utilization of maternal health services (Ibrahim, Sufiyan, Idris, Asuke, Yahaya, Olorukooba and Sabisu, 2014). In such a case, women have little or no autonomy outside the decision making power of their husbands (Umar, 2017). A study conducted in Nepal found that male partners are an important factor for maternal health decision making(Lewis et al, 2015). In low-income countries like Nigeria and a traditionally cultural state like Ibadan where patriarchy is held in high esteem, men are not included in labour or birth affairs (Vehvilainen-Julkunen and Emelonye, 2014).

Instead, they would rather relegate these duties to other female family members. This is also the same as in the case of an assisted delivery such as caesarean section. Despite this, the choices of what is to be done for the woman and child are often run through them in a patriarchal society for financial support, final approval and decision making as shown by the studies of Roudsari et al (2018) and Aziken et al (2007). Men's decision making on women's health especially when it concerns operative delivery like caesarean section may largely depend on fear, the dominant cultural views, income and the outcome of the procedure rather than a clinical understanding of the risk factors and benefits associated with the procedure (Odimegwu et al, 2005).

In African society, it is culturally not proper for a male partner to stay in the labour room during the labour or operation (in cases of caesarean sections). The involvement of the male partner stops at providing finance while other more personal matters concerning the childbirth are left to female family members. Although not much study has been done on the attitude and direct involvement of male partners towards caesarean section, other studies on the attitude of women cite some examples of male partner's involvement. One such study by Roudsari et al (2018) quotes a 27-year-old pregnant woman as saying "My male partner tells me that if I have a natural birth, we will have sexual problems in future"

The above statement shows that the said male partner has a direct influence on the choice of the delivery method the woman would take. The woman is more likely to opt for a caesarean section in a bid to sexually satisfy her male partner in future. Meanwhile, another study by Aziken et al (2007) contrasted with this when all the women involved in the study stated that their male partners were not happy that they delivered by a caesarean section. They were very much concerned about the reactions of their male partner. Another study reported an extreme incidence on how a particular husband refused his wife to have a caesarean section and moved her to a different hospital where she laboured for two days and then lost the baby, ruptured her bladder and developed infections (Udobang, 2018).

In another study by Ezeome et al (2018), 82% of the women stated that they would agree to a caesarean section as a mode of delivery if their male partners consented and despite their

personal disapproval because he is the head of the home. The younger women were of the view that the decision about the mode of delivery is to be made by the male partners. This is probably because, in a typical African setting, the man is older and holds a higher degree of dominance(Ezeome et al, 2018). Thus most men are the decision-makers in their homes (Tajuddin and Shamsuddin, 2015).

2.8 Factors That Might Affect Male Partners Attitudes towards Caesarean Section

Many reasons apart from the personal and medically indicated ones influence the decision making power of a pregnant woman. The increasing rate of caesarean section evidently is a multi-factorial problem, concerning the institutional practices, the physician, social women characteristics and their environment (Soto-Vega et al, 2015).

2.7.1 Sociocultural Factors

From time immemorial, societal norms and cultural values have always affected and influenced our decisions as humans. This is no different from the typical African man who relies on informal information to make decisions about his wife's pregnancy and mode of delivery. Male's opinion about caesarean section is mostly within a cultural context with the predominant view being that caesarean section is a sign of reproductive failure, with fatal consequences (Odimegwu et al, 2005) This informal information is often in forms of 'gist' from friends (Roudsari et al, 2015), advice from family members, threats from in-laws, rules by male partner and so on. In a particular study, the women believed that vaginal delivery is the culturally acceptable means of delivery and that caesarean section was a deviation from the norm (Ezeome et al, 2018). Literature reveals that although caesarean section is an ideal in developed countries; in developing countries, social and cultural responses obtainable are for women to reject caesarean section due to certain beliefs (Amiegheme et al., 2016).

One of the main sources of information for selecting the mode of delivery is the account of experiences mothers hear from other women and friends. These "birth stories" are mostly concerned with unpleasant aspects of childbirth, such as physical pain, the pressure at the time of delivery, the attitude of the midwives, and emergencies. Social media is another

avenue by which pregnant women are influenced and the decision for a caesarean section might be in a bid to associate with a certain social class.

2.7.2 Economic Factors

Many individuals have often complained of the cost of caesarean sections as against that of normal delivery. In a study on the attitudes and attitudes of pregnant women towards caesarean section, (Aziken et al, 2007), the cost was the third major reason why the respondents who rejected caesarean section did so. The cost of a single procedure of caesarean section is relatively high when compared to normal vaginal delivery. This explains why caesarean section rates are increasing more in the private sector than in the public sector (Soto-Vega et al, 2015). This will be a more important matter to the man due to his traditionally recognized role as the one who bears the financial burdens in the home.

Caesarean section has far-reaching economic consequences that graduate from the individual with factors such as low family income, unemployment of male partner, financial pressure from raising other children (Chigbu et al, 2007), to the national economy by putting financial burdens on already overweighed health systems(Betran et al, 2016).

2.7.3 Education

In a study of factors influencing caesarean section delivery in India Balmur and Guthi (2017) identified education as one of the factors affecting the utilization of caesarean section. Caesarean rates in this study were higher with people who had secondary and tertiary education than those who had only primary education (Balmur and Guthi, 2017). In a study by Ezeome, more people with tertiary education are more inclined to accepting caesarean section, but women with tertiary education were less likely to accept caesarean section if they do not want to, despite their male partners' approval and vice-versa (Ezeome et al, 2018). Studies have shown that the level of education of respondents is directly proportional to their knowledge and sometimes to their attitude towards a particular phenomenon.

2.7.4 Psychological Factors

Fear of death is most times in itself the most stated reasons for refusal of a caesarean section (Aziken et al, 2007; Amiegheme et al, 2016; Chigbu et al, 2007). Due to the high rate of

Maternal mortality especially in developing countries, many women and their male partners may not want to undergo a caesarean section due to stories of operative failures they might have heard. Caesarean section is seen by certain people as a deviation from the norm. It is not unheard of for people to view a woman who has had a caesarean section as lazy and a reproductive failure (Ezechi et al, 2004). These views of shame are from friends, family members and male partners as well. She is often seen as not fit to be a mother.

2.8 Theoretical Framework

The Health Belief Model is one of the first theories of health behaviour and remains one of the most widely recognized. It is a model that creates a relationship between people's health-related beliefs and subsequent behaviours. It hinges on six main constructs on which people act the way they do

2.8.1 Perceived susceptibility: This is the individual's belief of being vulnerable to a particular condition as a result of that action e.g. the belief of a male partner that his wife or newborn are vulnerable to developing complications during or after a caesarean section. If they believe they are susceptible to such ill fate, they are likely to have a negative attitude towards caesarean section and to oppose their wives undergoing the procedure.

2.8.2 Perceived severity: This is the belief of an individual on how severe the risks are e.g. the belief by male partners that caesarean sections are very dangerous and can lead to maternal or fetal death. If the male partner perceives that the risks of caesarean section are very severe, he will be against his wife undergoing a caesarean section

2.8.3 Perceived benefits: The benefits of doing the behaviour as perceived by the individual i.e. the belief of a male partner that undergoing a caesarean section has benefits for his wife and unborn child e.g. avoidance of labour pain. The male partner might also believe that some benefits will come to him e.g. preservation of sexual function (Roudsari et al, 2015). If a male partner has these beliefs, then he will support a decision by his wife to undergo a caesarean section and even suggest it even when it has not been medically indicated.

2.8.4 Perceived barriers: An individual's attitude of the difficulties that stop them from following a specific behaviour and performing an action i.e. a particular traditional or religious belief influencing a male partner's attitude of caesarean section. Some traditions believe vaginal delivery to be a sign of a woman's strength and caesarean section is seen as a sign of failure or laziness (Roudsari, 2015) in such a setting, the male partner may have a negative attitude and attitude towards caesarean sections and see it as a sign of weakness.

2.8.5 Cues to action: The reinforcing factors that help and encourage individuals to make healthy related decision e.g. a male partners or father's attitude of caesarean section may be influenced positively or negatively due to reports from significant others like family members, friends, neighbours, co-workers e.t.c. whose wives have undergone a caesarean section. It will be positive if the caesarean section procedure by such significant others was

successful or negative if it was not successful.

2.8.6 Self-efficacy:

the confidence felt by the individual when carrying out certain health behaviours i.e. a male partner's belief and confidence in his wife as being strong enough and healthy to undergo a caesarean section procedure and also the confidence in the health service being rendered and the expertise and ability of the health workers.

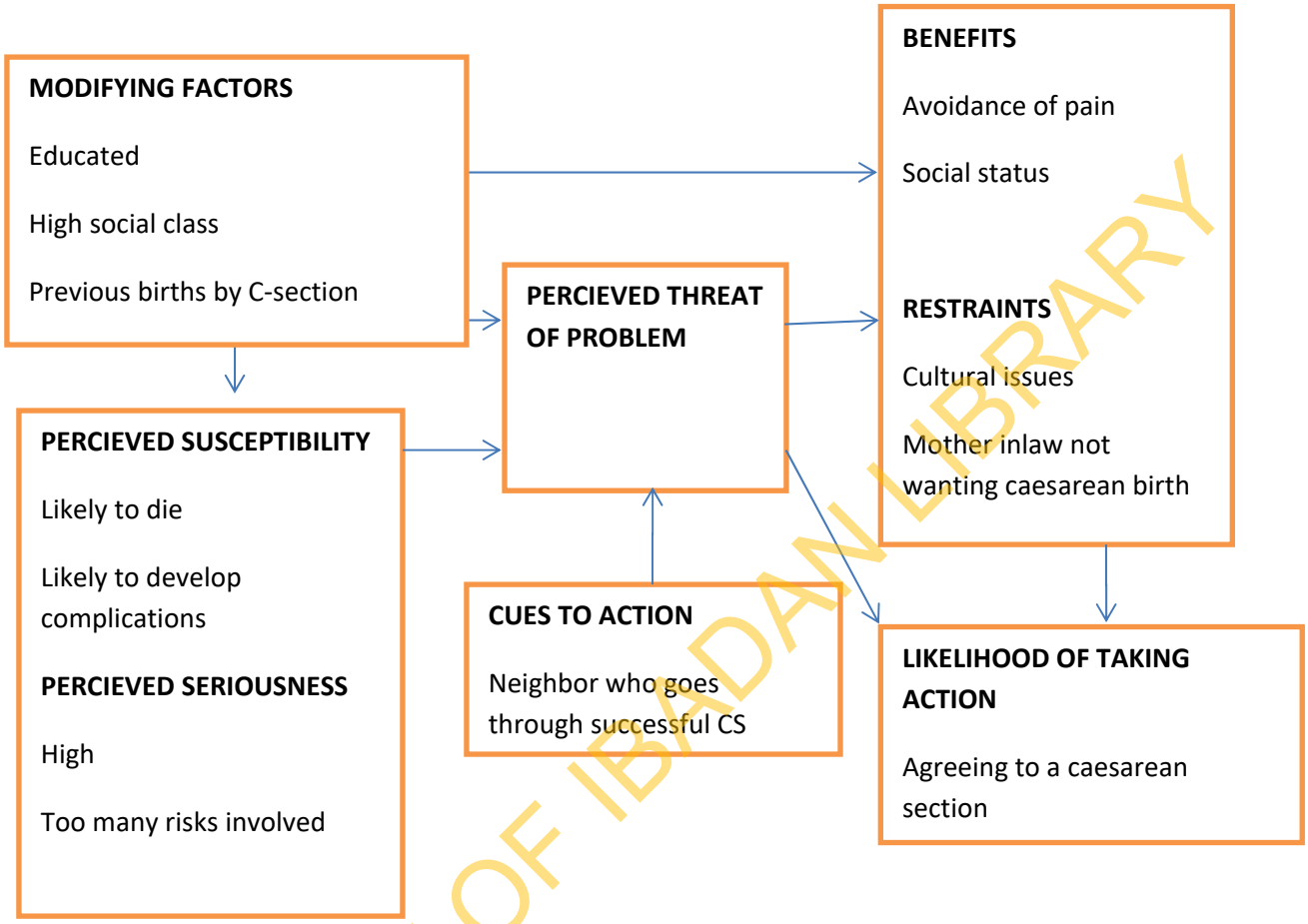

Figure 2.1 Health Belief Model

2.9.1 Application of the Health Belief Model to the Study

Perceived susceptibility: according to this study, perceived susceptibility is the respondents' belief that their wives or unborn children are vulnerable to death from complications of caesarean section. 57.9% of the respondents fear that a woman can die if she undergoes caesarean section. This belief that they are susceptible to lose their wives through caesarean section leads to a negative attitude towards it and oppose their wives undergoing the procedure.

Perceived severity: These were the beliefs of the respondent on the severity of the risks of caesarean section e.g. the belief by male partners that caesarean sections are very dangerous and can lead to maternal death. 63.8% of the respondents believe that caesarean sections are very dangerous (Q42)

Perceived benefits; in this study: the perceived benefits of caesarean section was to save lives. The men agreed that they would only support their wife for a caesarean section as a last resort to save lives. The perceived benefits of saving lives will make the respondents support a decision by his wife to undergo a caesarean section.

Perceived barriers: the perceived barriers are constraints or difficulties that stopped the respondents from performing an action (supporting caesarean section) i.e. in the case of this study, the perceived barriers are fear and financial constraints of the male partner. Other very important barriers are cultural norms and religious expectations.

Cues to action: based on this study, the cues to action were the sociodemographic characteristics of the respondents. For example, respondents see money as a reinforcing factor for undertaking caesarean section. Those of the respondents who earn more are more likely to support their wives undergoing caesarean section. This was emphasized in questions 31 and 32. About 79.3% of respondents will consider a caesarean section if the price was reduced. Another cue to action is the respondents' educational level. Education

CHAPTER THREE

METHODOLOGY

3.1 Study design

A descriptive cross-sectional design was used in this study to measure and investigate the knowledge and attitude of male partners towards caesarean section in Ibadan north local government area, with participants selected from randomly selected communities in Ibadan north local government area.

3.2 Study area

This study was carried out in Ibadan North Local Government Area. Ibadan North Local Government is one of the five local governments in Ibadan, Oyo state. It is a local government that covers a wide expanse of lands and as a result, it is highly populated. It also has 12 wards which cover communities like Bere, Oke Are, Adeoyo, Oje, Yemetu, Bodija, Ashi, Sabo, Mokola, Sango, Awolowo, Samonda, University of Ibadan, Agbowo, Total Garden, Ikolaba, Gate, Secretariat, Barika and so on.

Ibadan North Local Government is mainly dominated by the Yoruba ethnic group, although, there are other ethnic groups from other parts of the country e.g. Igbo, Hausa, Edo. Urhobo and some foreigners from outside the country who currently reside in communities within Ibadan North Local Government Area. A greater number of the people who live in Ibadan North Local Government Area are workers in the private sector, traders and artisans.

The main religions practised in this local government area are Christianity and Islam with a few traditional worshippers. This is evident by the number of churches and mosques scattered around the local government area. Some communities of Ibadan north local government area are low-class communities showing characteristics of slums such as overpopulation, lack of basic amenities, and unplanned housing patterns e.g. Yemetu and Bere. Other communities in this local government area can boast of a higher level of social status with well-planned houses, tarred roads, basic amenities and more. They include communities like Bodija, Bashorun, Agodi, Samonda and so on.

The main institutions of learning in Ibadan north local government area are the prestigious university of Ibadan which is the foremost university in Nigeria with affiliates all over the country and in some parts of the world. Others are the Ibadan Polytechnic and the University College Hospital, Ibadan. Ibadan North Local Government Area boasts of the highest number of health facilities in the state. There are also a good number of markets in the local government area. The area also has some recreational facilities and tourist sites such as the University of Ibadan Zoological Gardens, Mapo Hall, Agodi Gardens and The Bower Tower e.t.c. Below are the 12 wards and corresponding communities that will be covered;

Ward 1: Beere, Kannike, Agbadagbudu, Oke-are, Odo-Oyo

Ward 2: Ode-oolo, Inalende, Oniyanrin, Oke Oloro

Ward 3; Adeoyo, Yemetu, Oke-aremo, Isale-alfa

Ward 4: Itu taba, Idi-omo, Oje-igosun, Kube, Oke-apon, Abonla, Total garden, NTA Area

Ward 5: Bashorun, Oluwo, Ashi, Akingbola, Ikolaba, Gate

Ward 6: Sabo

Ward 7: Oke-itunu, Coca-Cola, Orimeji

Ward 8: Sango, Ijokodo

Ward 9: Mokola, Ago Tapa, Premier Hotel

Ward 10: Bodija, Secretariat, Awolowo, Obasa, Sanusi

Ward 11: Samonda, Polytechnic, and University of Ibadan

Ward 12: Agbowo, Bodija Market, Oju Irin, Barika, Iso Pako, Lagos-Ibadan express road

3.3 Study population

The study population was made up of male partners who are married or unmarried, who have had at least one child in the last 10years or whose wives have been pregnant at least once in Ibadan North Local Government Area and who also gave their consent to participate in this study, Irrespective of their social status, occupation, religious or political affiliation.

3.4 Inclusion criteria

All male partners, married or unmarried, who consented to participate in this study and have at least one child or have had their female partners pregnant at least once

3.5 Exclusion criteria

All male partners who did not have a child or whose female partners have never been pregnant and all women were excluded from this study. Also excluded were all men who did not consent to participate in the study

.

3.6 Sample size

The sample size will be determined using the Leslie Kish formula

$$n = \frac{Z^2pq}{d^2}$$

Where n= minimum sample size

p=the proportion of the target population estimated to have a particular phenomenon of the interest in the study (prevalence of caesarean section in a tertiary hospital in Enugu is 25.7% [Ezugwu et al, 2017])

q= 1-p

q= 1- 0.257

q= 0.743

Z= critical value of 1.96 at 5% (95% confidence interval)

d= precision limit (limit of error) for the purpose of this study (0.05)

$n= (1.96)^2 \times 0.257 \times 0.743 / (0.05)^2$

n= 293.5

A non-response rate of 10% of 293.5 = 29.35

Therefore, 29.35was added to the sample size calculated to make the sample size 293.5 in order to address issues of incomplete response.

322.85 will then be the sample size ≈ 323

3.7 Sampling technique

The sampling technique that was employed was a four-stage sampling procedure to select respondents in Ibadan North Local Government Area which has a total of 12wards.

Stage 1: Simple Random sampling was used to select 50% of the wards by balloting

Stage 2: From each of the six (6) wards selected, two (2) communities were picked through simple balloting

Stage 3: The houses in each of the 12 communities chosen were enumerated

Stage 4: Systematic sampling was used to select from the houses enumerated in the communities, using a predetermined interval of "k" (to avoid bias) k=20

Stage 5: Individuals who fit the inclusion criteria for this study were randomly selected from the determined houses to participate in the study.

3.8 Instrument for data collection

A valid questionnaire was drafted to gather data from the proposed respondents. The study questionnaire was interviewer-administered. The questionnaire was drafted in the English language based on the study objectives. It was then be interpreted into the local language which is Yoruba and re-interpreted into the English language again to ensure that the contents of the questionnaire were retained and remain the same. The questionnaire was pretested in Ibadan North East Local Government Area, a similar local government to ensure the validity of the questionnaire.

- The first section of the questionnaire contained the sociodemographic information of the participant
- The second section measured the previous knowledge of the participant concerning caesarean section
- The third section ascertained the male partner's attitude towards caesarean section
- The fourth section was designed to determine the factors affecting the attitude of male partners towards caesarean section

3.9 Validity

The validity of the instrument was determined by conducting an extensive literature review, ensuring that the instrument was in line with the objectives of the study. It was also determined by peer review of the instrument and review by relevant professionals. The questionnaire was translated to the local language which is Yoruba and back to English to ensure the variables remain the same

3.9.1 Reliability

The reliability of the instrument was determined by conducting a pretest with 10% of my sample size in Ibadan North East Local Government Area which is a population with similar characteristics. Cronbach's Alpha and reliability coefficient were used to measure reliability. A coefficient of 0.732 was obtained indicating that the instrument is reliable.

3.9.2 Data Collection Procedure

For the purpose of this study, three research assistants were recruited and trained. Their training consisted of how to watch for non-verbal cues, how to elicit responses from the participant, explaining the purpose of the research to the participants as well as the need for informed consent. The data was gathered with questionnaires over a period of 2 weeks. The questionnaire was explained by the interviewer to ensure that the participants understand each question and due consent was sought before the data collection procedure began. For each question asked, the interviewer ticked the appropriate answer on the part of the box reserved for such an answer. Data were collected from participants either in their homes or in their places of work. The participants were also enlightened on the objectives of the study before proceeding to answer the questionnaire.

3.9.2 Data Management and Analysis

After data collection, the copies of the questionnaire returned were arranged and checked for accuracy, incomplete ones were removed. A coding guide was developed for ease of data entry. The coding guide was then developed and codes were allotted to the different variables under study. The data was entered into a computer and the analysis of the data was done using Statistical Package for Social Sciences (SPSS version 22).

The data were analysed with descriptive and inferential statistics and the 18-point knowledge scale was categorised as poor (<6), fair (≥6-12) or good (≥12). The 10-point Attitude scale was also categorised as positive (>5) or negative (≤5)

.

3.9.3 Ethical Considerations

The study was conducted in accordance with the stipulated ethical rules and guidelines concerning the use of human participants in research. Appropriate steps were taken to ensure

the ethical conduct of this research. Ethical approval was sought from the Oyo State Ministry of Health research ethical review board before going to the field (appendix 4). The questionnaire was drafted with due respect for the participants and their privacy. Consent was duly obtained from the participants before the questionnaires were administered in order to gain their full cooperation.

The participants were assured of utmost confidentiality of the information provided so as to be able to ensure sincere responses. They were assured that they can decide not to continue if they feel uncomfortable at any point during the study. Participants were also encouraged to ask questions to clarify any areas that they did not understand.

CHAPTER FOUR

RESULTS

4.1Sociodemographic Characteristics of the Respondents

The ages of the respondents ranged from 20 to 70 years. A greater portion of the respondents were in the middle-age (40-60yrs) and young men (20-40yrs) with 44% and 42.7% respectively. Such a wide age range accounted for men who married a second or third wife later in life and those who remarried at the demise of their wives. The ethnicity of the respondents was predominantly Yoruba (91%) while other ethnic groups like Hausa (2.2%) and Igbo (5.9%) and Edo (0.9%) were also accounted for. The respondents were majorly educated up to the tertiary level (47.7%) and secondary school level (40.2%), with only 3.1% having no education and 9% who stopped at the primary school level. The occupation of the respondents ranged from artisans (10.8%), civil servants (18.0%), self-employed individuals (36.2%), and traders (29.1%). Those who were either retired or pensioners made up 3.4% of the respondents, while 2.2% were unemployed. The predominant religions were Christianity (53.3%) and Islam (46.4%) with only 0.3% of traditionalists. The married respondents were 91.3%, with 27.8% of the marriages being polygamous and 72.2% being monogamous. Others were either single (5.3%), divorced (0.9%) or separated (2.5%). Majority of the respondents earn below 100000 (42.7% earn <50,000 and 39.9% earn between 50,000 and 100,000naira irrespective of the size of their families. Over half of the respondents (76.8%) have 1-4 children, 22.0% have 5-8 children, while 1.2% of the respondents have 9 children and above (Table 4.1).

Table 4.1a: Sociodemographic Information of Respondents (N=323)

Sociodemographic information	Frequency	Percent
Ethnicity		
Yoruba	294	91.0
Igbo	19	5.9
Hausa	7	2.2
Others (Edo)	3	0.9
Age (Mean age 44.8 ± 11.4)		
20-40 years	138	42.7
40-60years	142	44.0
>60years	43	13.3
Marital status		
Single	17	5.3
Married	295	91.3
Divorced	3	0.9
Separated	8	2.5
Type of marriage		
Polygamous	82	27.8
Monogamous	213	72.2
Number of children		
1-4	248	76.8
5-8	71	22
>8	4	1.2
Average monthly income		
<₦50k	138	42.7
₦50-₦100k	129	39.9
₦100-₦150k	38	11.8
>₦150k	18	5.6

Table 4.1b: Sociodemographic Information of Respondents contd. (N=323)

Socio demographic information	Frequency	Percentage (%)
Educational level		
None	10	3.1
Primary	29	9.0
Secondary	130	40.2
Tertiary	154	47.7
Occupation		
Artisans	35	10.8
Civil servants	58	18.0
Self employed	117	36.2
Trader	94	29.1
Unemployed	7	2.2
Pensioner/ retired	11	3.4
Others	1	0.3
Religion		
Christianity	172	53.3
Islam	150	46.4
Traditionalists	1	0.3

4.2 Respondents Awareness of Caesarean Section

Descriptive analysis of the respondent's level of awareness clearly indicates that the level of respondent's awareness about caesarean section was very high. A majority of the respondents (95.4%) which is about 308 out of a total of 323 respondents that participated in the study had heard about caesarean section in one way or the other. Only 4.6% responded that they had not heard about caesarean section before.

4.3 Respondents knowledge of cesarean section

A majority of the respondents correctly responded to many of the knowledge questions which are: caesarean section was done by cutting a woman's abdomen (91.9%), a procedure to remove a tumor is also called a caesarean section (62.3%), caesarean section can also be by choice (59.1%), a sweet sensation does not happen during a caesarean section (92.5%), any woman can undergo a caesarean section (55.2%), breech presentation of the child is a medical reason for caesarean section (90.9%), overweight baby is a medical reason for caesarean section(92.2%), previous caesarean section is a medical reason for caesarean section (64.3%), multiple babies is a reason for caesarean section(71.8%), who benefits most from a caesarean section(65.6%). The respondents' knowledge about the clinical complications that can arise due to a caesarean section was also generally high; death (94.5%), bleeding (88.3%), malaria (80.2%), mental problems (57.5%), infections (70.8%). But a majority of the respondents (63.6%) wrongly responded that depression is a clinical complication of caesarean section, fear of labour is a medical reason for caesarean section (74.0%), and fear of death is a medical reason for caesarean section (58.4%). Out of the 308 respondent who had displayed an awareness of caesarean section, 60.1% had good knowledge about the procedure, 39.6% had fair knowledge and 0.3% had poor knowledge

Data showed that among age groups, men between the ages of 20-40years and 40-60years generally had more knowledge than those who were above 60years. The data also showed that knowledge of caesarean section was higher among Christians as 68.9% of the 167 Christians who participated in this study made up 62.2% of those who had good knowledge about the procedure, as opposed to 49.3% (69 respondents) of the total number of Muslims who made up 37.3% of those who had good knowledge about the procedure. Data analysis also reports that education seems to be a prerequisite for knowledge of caesarean section

among the respondents as 77.9% of all those who had tertiary education (149 out of 323 respondents) had more knowledge about caesarean section than those respondents who just had secondary and primary education or no education at all. Data also showed that higher income translates to a better knowledge of caesarean section as those who make an average income of above 150,000 per month also have more knowledge of caesarean section than people who make less (Table 4.2).

Table 4.2: Respondents' knowledge of caesarean section

Knowledge of caesarean section	Frequency	Percent
A CS is done by cutting a woman's abdomen *	283	91.9
A procedure to remove a tumor is also called a CS	192	62.3
Caesarean section can also be by choice *	182	59.1
Sweet sensation cannot happen during a CS *	285	92.5
Any woman can undergo a CS *	170	55.2
Medical reasons for CS- Breech presentation of the baby*	280	90.9
Overweight child *	284	92.2
Fear of labour pain	80	26.0
Fear of death	128	41.6
Previous experience of CS *	198	64.3
Multiple babies *	221	71.8
Mother benefits most from CS*	202	65.6
Clinical complications from CS- Death*	291	94.5
Depression	112	36.4
Bleeding *	272	88.3
Malaria	247	80.2
Mental problems	177	57.5
Infections *	218	70.8

Correct answers *

Table 4.3: Respondents overall knowledge score

Knowledge category	Frequency	Percent (%)
Poor (0-6)	1	0.3
Fair (>6-12)	176	57.1
Good (>12)	131	42.5
Total	**308**	**100.0**

4.4 Respondent's attitude towards caesarean section

While the respondents' knowledge of caesarean section was quite high, their attitude towards the procedure was poor. Data showed that 176 respondents (54.5%) had negative attitude towards caesarean section while 147 respondents (45.5%) had positive attitude towards caesarean section. From the responses, 67.8% did not consider caesarean section as a good thing or were undecided about it. A larger number of the respondents will support their wife's decision to go through with a caesarean section. Only 40.9% responded correctly to the question, "I believe only women with complications should go through a caesarean section".

A large percentage of the respondents disagreed that caesarean section was only meant for people of high social class. Most of the respondents also believe that women and their babies can survive caesarean section. About 73.7% of the respondents believe that caesarean section can limit the number of children a woman can have. Still, 44.6% agree that a woman cannot always have control over her mode of delivery and 79.3% will only ever accept caesarean section as a last resort. Statistics showed that 55.7% of the respondents believe that caesarean section can be conducted without complications. Despite the negative attitude towards caesarean section, a staggering 92.0% do not think that caesarean section should be abolished (hypothetically) (Table 4.4).

Table 4.4: Respondents attitude towards caesarean section

Attitude statements	Agree (%)	Undecided (%)	Disagree (%)
I consider caesarean section to be a good thing	104(32.2)*	51(15.8)	168(52.0)
I can support my wife's decision to give birth through a caesarean section	174(53.9) *	43(13.3)	106(32.8)
I believe only women with complications should go through a caesarean section	174(53.9)	17(5.3)	132(40.9)*
I consider caesarean section as a procedure meant only for people of high social class	17(5.3)	32(9.9)	274(84.8) *
I am of the opinion that people hardly survive caesarean section	35(10.8)	52(16.1)	236(73.1) *
I believe that caesarean section can limit the number of children a woman can have	203(62.8)	35(10.8)	85(26.3) *
I believe a woman should have control over her mode of delivery	128(39.6)	51(15.8)	144(44.6) *
I will only accept caesarean section as a last resort	215(66.6)	41(12.7)	67(20.7) *
I believe caesarean sections cannot be performed without complications	84(26.0)	59(18.3)	180(55.7) *
I think caesarean sections should be banned	7(2.2)	19(5.9)	297(92.0) *

***positive response**

Table 4.5: Respondent's overall attitude score

Attitude score	Frequency	Percentage (%)
Negative (<5)	176	54.5
Positive (>5-10)	147	45.5
Total	**323**	**100.0**

4.5 Factors that affect the attitude of respondents towards caesarean section

The study shows the respondents' responsiveness towards factors that affect their attitude concerning caesarean section. The factors considered included the economic factors, sociocultural factors, psychological factors and religious factors. The responses show that most of the respondents do not agree that economic factors are an important factor in considering caesarean section. Using descriptive analysis, about 92.2% of the respondents believe that caesarean sections are too expensive, while 86.1% are of the opinion that it is the high cost of the procedure that discourages its use. About 82.4% of men states that many people cannot afford to undergo a caesarean section even if it is compulsory. Also, 79.3% responded that people will be more open towards a caesarean section if the cost of the procedure were to be reduced (Table 4.6a).In responding to the sociocultural questions, 92.9% said that caesarean section is not a taboo in their cultures. Meanwhile, 93.5% disagree with the statement that a woman does not attain motherhood if she undergoes a caesarean section. The data shows that 78.0% responded 'No' to the statement that anyone that has had a caesarean section cannot have normal vaginal delivery again. While 72.8% of the respondents did not agree that caesarean section may reduce a woman's sexual function. More than half of the respondents (84.5%) disagreed that caesarean section means a woman is weak and 72.8% also disagreed that caesarean section can destroy a woman's body. About 79.9% stated that their family members will not go against their decision for caesarean section (Table 4.6a). In responding to the psychological factors, most of the respondents (79.3%) do not agree that caesarean section can lead to the breakup of a marriage. But 63.8% of the respondents unanimously agreed that caesarean section is very dangerous. The respondents had conflicting views about the ability of a woman or child to survive caesarean sections as 52.0% disagreed to the statement that a child can die if delivered through a caesarean section, while 48.0% percent agreed. Over 92.3% were of the opinion that the lifespan of the child does not depend on the mode of delivery (Table 4.6a).Most of the respondents do not agree that caesarean section is against their religious beliefs; they also do not agree that caesarean section undermines divine power. Only 21.7% agreed that caesarean section should be forsaken if a pastor or imam advises against it. Only 13.3% believe that the indication for the use of caesarean section is as a result of supernatural forces (Tables 4.6b).

Table 4.6a Factors affecting respondent's attitude towards caesarean section (n=323)

FACTORS	YES (%)	NO (%)
Economic factors		
Caesarean sections are too expensive	299(92.6)	24(7.4)
High costs of caesarean sections discourage its use	278(86.1)	45(13.9)
Many people cannot afford a CS even if it is necessary	266(82.4)	57(17.6)
People will consider a caesarean section if the price is reduced	256(79.3)	67(20.7)
Sociocultural factors		
Caesarean section is a taboo in my culture	23 (7.1)	300(92.9)
A woman does not attain motherhood if she undergoes a CS	21 (6.5)	302 (93.5)
Anyone that has had a CS cannot have a normal vagina delivery again	71 (22.0)	252 (78.0)
Caesarean section is not in line with our culture	84 (26.0)	239 (74.0)
Having a CS may reduce a woman's sexual function	88 (27.2)	235 (72.8)
Caesarean section means a woman is weak	50 (15.5)	273 (84.5)
Caesarean section destroys a woman's body	88 (27.2)	235 (72.8)
My family members will go against caesarean section	65 (20.1)	258 (79.9)
Psychological factors		
Caesarean section can lead to the breakup of a marriage	67 (20.7)	256 (79.3)
Caesarean sections are very dangerous	206 (63.8)	117 (36.2)
A child can die if birthed through a caesarean section	155 (48.0)	168 (52.0)
A woman can die if she goes through a caesarean section	187 (57.9)	136 (42.1)
Babies from a caesarean section do not live long	25 (7.7)	298 (92.3)
Religious factors		
Caesarean section is against my religious beliefs	17 (5.3)	306 (94.7)
Caesarean section undermines divine power	23 (7.1)	300 (92.9)
CS should be forsaken if a pastor/imam advises against it	70 (21.7)	253 (78.3)
Caesarean section is as a result of supernatural forces	43 (13.3)	280 (86.7)
Children are a gift from God and caesarean section negates that	13 (4.0)	310 (96.0)

4.6 Test of Hypotheses

Hypothesis one: There is a significant association between respondents' sociodemographic characteristics (educational level, religion, average monthly income) and their knowledge about caesarean section. Table 4.6 shows the association between the respondent's sociodemographic characteristics and their knowledge of caesarean section. Their sociodemographic responses were gathered in age, educational level, occupation, ethnicity, number of children, average monthly income, marital status and type of marriage.

The respondents' knowledge scores were compared with their age. As shown in the table, the majority of the respondents who had very good knowledge were middle-aged men. There was however no significant association between the age of the respondents and their knowledge on caesarean section (p= 0.293). There was also no significant association between the ethnicity of respondents and their knowledge of caesarean section. There is no association between respondent's occupation and their knowledge of caesarean. The comparison of respondent's religion with their knowledge score shows that 68.9% of respondents with a good knowledge score. Thus there is a significant association between religion and respondents knowledge of caesarean section. Cross-tabulation of educational level shows that education has a highly significant association with knowledge of respondent concerning caesarean section (p= 0.000). Among the educated respondents, those who have tertiary education have a better knowledge of caesarean section. Marital status and number of children have no significant association with respondents' knowledge. There is a highly significant association between the respondent's average monthly income and their knowledge of caesarean section (Table 4.6a).

Table 4.7a: Sociodemographic information of respondents relating to their level of knowledge

Variables	Knowledge score category			X^2	Df	P-value
	Poor (%)	Fair (%)	Good (%)			
Age						
20-40	1 (0.8)	46 (35.9)	81 (63.3)	4.673	4	**0.293**
>40-60	0 (0.0)	55 (39.6)	84 (60.4)			
>60	0 (0.0)	21 (51.2)	20 (48.8)			
Ethnicity						
Yoruba	1 (0.4)	112 (39.7)	169 (59.9)	12.237	6	**0.180**
Hausa	0 (0.0)	2 (50.0)	2 (50.0)			
Igbo	0 (0.0)	5 (26.3)	14 (73.7)			
Others	0 (0.0)	3 (100.0)	0 (0.0)			
Occupation						
Artisans	0 (0.0)	18 (56.3)	14 (43.8)	20.967	12	**0.120**
Civil servants	0 (0.0)	15 (26.3)	42 (73.7)			
Self employed	1 (0.9)	48 (43.2)	62 (55.9)			
Traders	0 (0.0)	33 (37.1)	56 (62.9)			
Unemployed	0 (0.0)	2 (28.6)	5 (71.4)			
Retired/Pensioners	0 (0.0)	6 (54.5)	5 (45.5)			
Others	0 (0.0)	0 (0.0)	1 (100.0)			
Religion						
Christianity	0 (0.0)	52 (31.1)	115 (68.9)	17.31	4	**0.001***
Islam	1 (0.7)	70 (50.0)	69 (49.3)			
Traditional	0 (0.0)	0 (0.0)	1 (100.0)			

Table 4.7b: Sociodemographic information of respondents relating to their level of knowledge

Variables	Knowledge score category			X^2	Df	p-value
	Poor(%)	Fair (%)	Good (%)			
Educational level						
None	0 (0.0)	5 (55.6)	4 (44.4)	46.654	6	**0.000***
Primary	0 (0.0)	18 (72.0)	7 (28.0)			
Secondary	0 (0.0)	67 (53.6)	58 (46.4)			
Tertiary	1 (0.7)	32 (21.5)	116 (77.9)			
Marital status						
Single	0 (0.0)	6 (40.0)	9 (60.0)	9.793	6	**0.432**
Married	1 (0.4)	111 (38.9)	173 (60.7)			
Divorced	0 (0.0)	2 (100.0)	0 (0.0)			
Separated	0 (0.0)	3 (50.0)	3 (50.0)			
Average income/month						
<50000	0 (0.0)	67 (51.9)	62 (48.1)	20.864	6	**0.001***
50000-100000	1 (0.8)	43 (34.4)	81 (64.8)			
100000-150000	0 (0.0)	10 (27.8)	26 (72.2)			
>150000	0 (0.0)	2 (11.1)	16 (88.9)			
Number of children						
1-4	1 (0.4)	89 (37.2)	149 (62.3)	6.261	4	**0.359**
5-8	0 (0.0)	31 (47.0)	35 (53.0)			
9-12	0 (0.0)	2 (66.7)	1 (33.3)			

***significant**

***Fisher's Exact**

Hypothesis 2: There is a significant association between some of the sociodemographic variables of respondents (occupation and average monthly income) and their attitude towards caesarean section. Table 4.7 shows respondents attitude towards caesarean section being cross-tabulated with their sociodemographic characteristics (age, ethnicity, religion, educational level, occupation, marital status, average monthly income and the number of children they have).

Fisher's exact test was used to determine the association between their sociodemographic variables and their attitude toward caesarean section. The fisher's exact tests conducted shows that there was no significant statistical association between most sociodemographic characteristics of respondents and their attitude towards caesarean section. P-value of 0.028 establishes that there is a significant statistical association between the occupation of the respondents and their attitude towards caesarean section. There is also a significant association between the respondent's average monthly income and their attitude towards caesarean section ($p = 0.021$) (Table 4.7)

Table 4.8a: Sociodemographic information of respondents relating to their attitude towards caesarean section

Variables	Attitude score category		X^2	df	p-value
	Negative (%)	Positive (%)			
Age					
20-40	78 (56.5)	60 (43.5)	0.424	2	0.809
40-60	75 (52.8)	67 (47.2)			
>60	23 (53.5)	20 (46.5)			
Ethnicity					
Yoruba	161 (54.8)	133 (45.2)	0.771	3	0.957
Hausa	4 (57.1)	3 (42.9)			
Igbo	9 (47.4)	10 (52.6)			
Others (Edo)	2 (66.7)	1 (33.3)			
Occupation					
Artisans	24 (68.6)	11 (31.4)	13.200	6	0.028*
Civil servants	24 (41.4)	34 (58.6)			
Self-employed	60 (51.3)	57 (48.7)			
Trader	60 (63.8)	34 (36.2)			
Unemployed	4 (57.1)	3 (42.9)			
Retired /Pensioner	4 (36.4)	7 (63.6)			
Others	0 (0.0)	1 (100.0)			
Religion					
Christianity	87 (50.6)	85 (49.4)	3.602	2	0.105
Islam	89 (59.3)	61 (40.7)			
Traditional	0 (0.0)	1 (100.0)			

Table 4.8b: Sociodemographic information of respondents relating to their attitude towards caesarean section

Variables	Attitude score category		X^2	Df	p-value
	Negative(%)	Positive(%)			
Educational level					
None	7 (70.0)	3 (30.0)	5.149	3	0.160
Primary	15 (51.7)	14 (48.3)			
Secondary	79 (60.8)	51 (39.2)			
Tertiary	75 (48.7)	79 (51.3)			
Marital status					
Single	12 (70.6)	5 (29.4)	5.819	3	0.101
Married	155 (52.5)	140 (47.5)			
Divorced	2 (66.7)	1 (33.3)			
Separated	7 (87.5)	1 (12.5)			
Average monthly income					
<50,000	84 (60.9)	54 (39.1)	9.699	3	0.021*
50000-100000	71 (55.0)	58 (45.0)			
100000-150000	16 (42.1)	22 (57.9)			
>150000	5 (27.8)	13 (72.2)			
Number of Children					
1-4	136 (54.8)	112 (45.2)	1.358	2	0.561
5-8	39 (54.9)	32 (45.1)			
9-12	1 (25.0)	3 (75.0)			

Hypothesis 3:

There is no significant association between the attitude of respondents towards caesarean section and their socio-economic status. Concerning this, we fail to reject the hypothesis. The analysis also shows that there is an association between sociocultural factors and respondents attitude of caesarean section. There is also a clear association between psychological factors and the attitude of respondents towards caesarean section. There is also an association between religious factors and caesarean section.

Table 4.9a: sociocultural factors relating to respondents attitude

Sociocultural variables	Attitude		X^2	Df	p-value
	Negative(%)	Positive(%)			
CS is a taboo in my culture					
Yes	17 (73.9)	6 (26.1)	3.768	1	0.052
No	159 (53.0)	141 (47.0)			
A woman does not attain motherhood after CS					
Yes	14 (66.7)	7 (33.3)	1.343	1	0.246
No	162 (53.6)	140 (46.4)			
Cannot have a vaginal delivery after CS					
Yes	47 (66.2)	24 (33.8)	5.030	1	0.025*
No	129 (51.2)	123 (48.8)			
CS is not in line with our culture					
Yes	62 (73.8)	22 (26.2)	17.088	1	0.000*
No	144 (47.7)	125 (52.3)			
Having a CS may reduce a woman's sexual function					
Yes	68 (77.3)	20 (22.7)	25.318	1	0.000*
No	108 (46.0)	127 (54.0)			
CS means the woman is weak					
Yes	44 (88.0)	6 (12.0)	26.789	1	0.000*
No	132 (48.4)	141 (51.6)			
CS destroys a woman's body					
Yes	68 (77.3)	20 (22.7)	25.318	1	0.000*
No	108 (46.0)	127 (54.0)			
My family members will go against CS					
Yes	52 (80.0)	13 (20.0)	21.356	1	0.000*
No	124 (48.1)	134 (51.9)			

*significant

Table 4.9b: Psychological factors relating to respondents attitude

Psychological Variables	Attitude		X^2	Df	p-value
	Negative(%)	Positive(%)			
CS can lead to break up of marriage					
Yes	45 (67.2)	22 (32.8)	5.477	1	0.019*
No	131 (51.2)	125 (48.8)			
CS is very dangerous					
Yes	138 (67.0)	68 (33.0)	35.839	1	0.000*
No	38 (32.5)	79 (67.5)			
A child can die if birthed through a CS					
Yes	107 (69.0)	48 (31.0)	25.416	1	0.000*
No	69 (41.1)	99 (58.9)			
A woman can die if she goes through a CS					
Yes	124 (66.3)	63 (33.7)	25.026	1	0.000*
No	52 (38.2)	84 (61.8)			
Babies from CS do not live long					
Yes	15 (60.0)	10 (40.0)	0.332	1	0.565
No	161 (54.0)	137 (46.0)			

*significant

Table 4.9c: Religious factors relating to respondents attitude

Religious Variables	Attitude Score		X^2	Df	p-value
	Negative(%)	Positive(%)			
CS is against my religious beliefs					
Yes	15 (88.2)	2 (11.8)	8.240	1	0.004*
No	161 (52.6)	145 (47.4)			
CS undermines divine power					
Yes	21 (91.3)	2 (8.70)	13.534	1	0.000*
No	155 (51.7)	145 (48.3)			
CS should be forsaken if the pastor /imam advises against it					
Yes	50 (71.4)	20 (28.6)	10.341	1	0.001*
No	126 (49.8)	127(50.2)			
CS is as a result of supernatural forces					
Yes	27 (62.8)	16 (37.2)	1.378	1	0.240
No	149 (53.2)	131 (46.8)			
Children are a gift from God and CS negates that					
Yes	11 (84.6)	2 (15.4)	4.957	1	0.026*
No	165 (53.2)	145 (46.8)			

4.7 Regression Analysis Showing the Correlation between Factors and Attitude of Respondents towards Caesarean Section

Sociocultural variables

Regression analysis was used to test the significance of the socio-cultural variables. Data showed that the variable "anyone who has had a caesarean section cannot have a normal vaginal delivery again" does not have a significant association with the attitude of respondents towards caesarean section. This also indicates that respondents who agree to this statement may not necessarily have a negative attitude towards caesarean section. The data also suggests that those respondents who believe that caesarean section is not in line with their culture are more likely to have a negative or poor attitude to caesarean section ($p=0.033$, $0.274 \leq CI \geq 0.948$). There is also a significant association between thinking that caesarean section means a woman is weak and attitude towards caesarean section. Respondents who think caesarean section indicates that a woman body is weak may not have a positive perception towards caesarean section.($p=0.002$). There is a significant association between the variable "caesarean section destroys a woman's body' and attitude towards a caesarean section.($p=0.019$) Respondents may also have a negative attitude towards caesarean section if their family members are likely to go against it. ($p=0.035$) (Table 4.9a)

.

Psychological Factors

Regression analysis on the psychological factors that affect the attitude of the respondents towards caesarean section revealed that there is a highly significant association between the belief that caesarean section is very dangerous and the respondents' attitude towards caesarean section ($p = 0.001$). This infers that the fear of caesarean section being a dangerous procedure will hamper a positive attitude towards it. The respondents that believe that caesarean sections are dangerous are 0.340 times more likely to have a positive attitude towards caesarean section (Table 4.9b)

Religious Factors

Regression analysis was done on the religious factors that influence an individual's attitude towards caesarean section. The results show that there is an association between the belief that caesarean section undermines divine power and attitude towards caesarean section

(p=0.022). This means that if people believe that caesarean section undermines divine power, the will have a negative attitude towards it. The regression analysis results also show that people will have a negative attitude towards caesarean section if their religious leaders (pastors/imam) advise against it. (p = 0.023) (Table 4.9c)

Table 4.9.1a: Regression analysis of sociocultural factors

	B	S.E	wald	df	p-value	Exp(B)	95% CI for exp(B)	
							lower	upper
Cannot have normal delivery after CS	-0.118	0.319	0.137	1	0.712	0.889	0.475	1.662
CS not in line with culture	-0.674	0.317	4.524	1	0.033	0.510	0.274	0.948
CS reduce woman's sexual function	-0.466	0.340	1.874	1	0.171	0.627	0.322	1.223
CS mean a woman is weak	-1.532	0.483	10.047	1	0.002	0.216	0.084	0.557
CS destroys woman's body	-0.774	0.329	5.532	1	0.019	0.461	0.242	0.879
Family members will go against CS	-0.785	0.373	4.432	1	0.035	0.456	0.220	0.947
Constant	0.607	0.163	13.823	1	0.000	1.835		

Table 4.9.1b: Regression analysis of psychological factors

	B	S.E	wald	df	p-value	Exp(B)	95% CI for exp(B)	
							lower	upper
CS can lead to break of marriage	0.005	0.321	0.000	1	0.987	1.005	0.536	1.884
CS is very dangerous	-1.080	0.321	11.333	1	0.001	0.340	0.181	0.637
A child can die through CS	-0.508	0.386	1.730	1	0.188	0.602	0.282	1.283
A woman can die through CS	-0.103	0.413	0.062	1	0.803	0.902	0.401	2.028
Constant	0.800	0.205	15.268	1	0.000	2.225		

Table 4.9.1c: Regression analysis of religious factors

	B	S.E	wald	df	p-value	Exp(B)	95% CI for exp(B)	
							lower	upper
CS is against my religious beliefs	-1.299	0.800	2.639	1	0.104	0.273	0.057	1.308
CS undermines divine power	-1.837	0.800	5.267	1	0.022	0.159	0.033	0.765
Forsake CS if pastor/imam against it	-0.696	0.306	5.172	1	0.023	0.499	0.274	0.908
CS is a result of supernatural forces	-0.208	0.362	0.329	1	0.566	0.813	0.400	1.651
CS negates children are a gift from God	-0.142	0.945	0.022	1	0.881	0.868	0.136	5.528
Constant	0.126	0.135	0.875	1	0.350	1.135		

CHAPTER FIVE

DISCUSSION, CONCLUSION, RECOMMENDATION

5.1 Discussion

5.1.1 Sociodemographic information of respondents

The findings of this study show that data was collected from fathers across different age groups with the mean age being 44.8 ± 11.4. A closer look at the sociodemographic characteristics of respondents this study also shows that the respondents are from different social classes based on their average monthly income, with the mean income of 73,693.50 ± 45.471.33. The major ethnic group is the Yoruba and this can be attributed to the study area being Ibadan North Local Government Area. Respondents who consented to participate in this study were majorly between the ages of 20-40(42%) and 40-60((44%). About 47.7% and 40.2% of the respondents have tertiary and secondary education respectively. Due to the study area used for this study, as expected, the study participants were mostly small business owners, traders and civil servants. 91.3% of the respondents were married, among these were 82 polygamous marriages. Polygamous marriages are often obtainable in traditional African societies irrespective of religion. More respondents earn below one hundred thousand naira monthly than above it. Most of the men and fathers in this study believe that the decision making ability rests on them. This is in agreement with the study of Ezeome et al in 2018 where a large number of the respondents believe that husbands should decide on the delivery mode.

5.1.2 Respondents Awareness about Caesarean Section

The respondents were asked whether they had ever heard of caesarean section and they were considered aware if they had ever heard of caesarean section as opposed to normal delivery. Overall, the awareness about caesarean section was very high among the respondents, this was consistent with the result of a study conducted in a Ghanaian teaching hospital (Adageba et al, 2008).

Among the respondents, the highest awareness level of caesarean section was from young and middle-aged people. This may be as a result of greater patronage of the internet by

younger people. The highest percentages of awareness across educational levels were among the secondary and tertiary educated respondents. However some of the respondents who had as high as a tertiary education were still no aware of caesarean section. This situation calls for the inclusion of caesarean section in antennal and couple health education in readiness for delivery. Far more Christian men (53.3%) have knowledge about caesarean section than their Muslim counterparts (46.4%). This corroborates the report of a previous study by Adewuyi et al in 2019. The disparity in knowledge by both faiths as compared to traditionalists is large; this suggests that these sets of respondent might have heard of caesarean section from their religious houses.

5.1.3 Respondent Knowledge on Caesarean Section

In this study, the respondents had an overall fair knowledge of caesarean section. The respondents showed a high level of understanding of the caesarean section procedure. Most of the respondents believe that caesarean section is a surgical procedure done by cutting a woman's abdomen, 62.3% also believe that a procedure to remove a tumor is also called a caesarean section. In line with the work of Adeoye and Kalu in 2011, this further emphasizes that many misconceptions about caesarean section still abound especially in traditional settings in Nigeria. Among the respondents, 44.8% believe that not any woman can go through a caesarean section, they believe the reasons for a caesarean section procedure should be pregnancy complications or distress or age of the mother. On this basis, many spouses may not support their wives going through a caesarean section, stressing that it is not for them.

Respondents knowledge of the reasons for caesarean section is also limited as many of the respondents as 74.0% picked fear(of labour) to be a medical reason for caesarean sections. A large percentage of the respondents (65.6%) agreed that a mother can benefit most from a caesarean section; this idea may be based on personal or shared experiences of how women's lives were saved through a caesarean section. This is in line with the WHO statement on the importance of caesarean section on maternal mortality rates. Respondents' knowledge about the clinical complications arising from a caesarean section was also very high.

On Further analysis using Fisher's exact test between sociodemographic characteristics of respondents and their knowledge, a cross-tabulation of the educational level of respondents and their knowledge of caesarean section shows that there is a significant association between educational level and respondents knowledge of caesarean section (X= 46.654, p= 0.000). This data is in contrast with the findings of Ezechi et al in 2004 when he stated that education had no effect on the attitude of respondents towards caesarean section but it Corroborates Adewuyi et al in 2019, Data also showed that education of fathers is important to the increased knowledge of caesarean section. There is no significant correlation between the age of respondents and their knowledge of caesarean section (X^2=4.673, p=0.293), their ethnicity and their knowledge(X^2=12.237, p=0.180).

5.1.4 Respondents Attitude on Caesarean Section

From indications in this study, 52% of the respondents disagreed that caesarean section is a good thing as against 32.2% who agreed and 15.8% who were undecided. Despite this disagreement about caesarean section being a good thing, 92.0% (almost everyone) of the respondents disagreed that caesarean section should be banned. This indicates that even with a misconception about caesarean section that it is not a good thing; the respondents may have a deeper understanding of the usefulness of the procedure. This falls consistently with the findings of Ezeome et al, (2018). In his study, the respondents are reluctant about caesarean section but they believe and agree that caesarean section is done for the safety of the mother and the child. About 66.6% agreed that they will only allow their female partners to undergo caesarean section if it becomes the last resort. Giedam, Audu, Kakuwa and Obed (2009) corroborated this in their study when he identified that 79.4% of births were performed as emergency caesarean section even though 78.9% of the births were booked as elective. A breakdown of this statement is in line with the findings of this study such that even though people are told to have a caesarean section, they would be averse to the idea until it is the last minute.

Using the chi-square test, it was found out that there is no statistical relationship between the age and the attitude of respondents towards caesarean section, between the ethnicity and their attitude towards caesarean section, between religion and their attitude towards caesarean

section, between their parity and their attitude towards caesarean section, between their educational level and their attitude, or even between their marital status and their attitude towards caesarean section. There is however a significant statistical association between the occupation of respondents and their attitude towards caesarean section (X^2= 13.200, df=6, p=0.028). There is also a clear statistical association between the average monthly income of respondents and their attitude towards caesarean section(X^2 =9.699, df=3, p=0.021). This may be interpreted as that people will undergo a caesarean section irrespective of their ages, ethnicity, marital status, religion, when they absolutely need to. They will only consider the cost based on their income or occupation. This is in line with the study of Harrison and Goldenberg in 2016 where they stated that there were concerns about the cost burdens caesarean section would place on families after the procedure. This was also affirmed by Aregbesola in 2016 when he stated that out of pocket payment for health services can be a big problem in Nigeria.

5.1.5 Factors Affecting Attitude towards Caesarean Section

The factor explored were economic, psychological factors, socio-cultural factors and religious factors. A large percentage of the respondents believe that caesarean sections are too expensive and others are of the opinion that this high cost discourages the use of caesarean section (86.1%). 79.3% of people will consider a caesarean section if the prices were subsidized. Binomial analysis showed that most people believe that caesarean sections are dangerous and this will affect their response in decision making to caesarean section. Data analysis shows that fear is a factor for the choice of caesarean section. This is in line with the study of Storken et al, 2015. When he said that fear could be an important emotion during childbirth and may complicate or prolong labour. This attitude of male partners to caesarean section will discourage involvement in the pregnancy and labour. This is in line with the study of Yokote in 2007 who said that the involvement of fathers in caesarean section has been largely ignored. Chibgbu and iloabachie reiterated this in 2007 when they stated that fear of caesarean sections often stems from previous experiences, loss of a loved one during a caesarean section or stories heard about caesarean section.

5.1.6 Implications for Health Promotion and Education

There are several implications of the knowledge and attitude of male partners concerning caesarean section on health promotion and education; It has been inferred from this study that although caesarean section is a phenomenon that has spread worldwide, the knowledge of men concerning the procedure is still limited.

Health education and enlightenment: according to the findings of this study, respondents' knowledge about caesarean section was just fair and not sufficient. The respondents believed many superstitions and misconceptions about caesarean section. Also, some of the respondents' information about caesarean section is from people who have had negative caesarean section experiences and from socio-cultural ideas. It is important that individual is provided with adequate health information as well as facts and statistics to improve their knowledge about caesarean section, to change their attitudes and to enable male partners especially to make informed decisions about caesarean section. Proper health information will also debunk misconceptions about caesarean section.

Advocacy and Formulation of Public Policy: The results of this study show that the respondents did not have sufficient knowledge of caesarean section and their attitude towards the procedure is poor as well. To improve this attitude, it is important that men be involved and engaged in women's reproductive health. To make this a reality, public policies should be set up to request the husband's or male partner's participation when women come for antenatal care. Women can have better pregnancy and birthing experiences while knowing that their husband supports them. Involvement of husbands and men in general in antennal visits, pregnancy and delivery will change the attitudes towards caesarean section. According to the World Health Organisation, improved male involvement is also vital for better outcomes in women's reproductive health. There is a need for policies that encourage and support male involvement in Female sexual and reproductive health.

Strengthening Health Systems: From this study, it was deduced that the major factors affecting men's attitude towards caesarean section are fear and the cost of the procedure. This calls for the strengthening of the Health system with the necessary technology needed to perform the procedure in such a way that complications and mortality are reduced to a minimum, in order to abate the fear concerning caesarean sections. Caesarean section can also be included in the National Health insurance scheme to subsidize the price and

encourage more people who are in dire need of it to engage. Care providers in understanding father's reactions and attitudes to caesarean section might help to strengthen the support from fathers and facilitate an understanding of couples' concerns and needs before, during and after birth

5.2 Conclusion

The findings in this study indicate that male partners in Ibadan North Local Government area have fair to average level of knowledge of caesarean section. The knowledge of caesarean section that they possess is mostly basic. The attitude of the respondents, however, is not a reflection of their knowledge, as the attitudes of the male partners were mostly negative. Further analysis of this study revealed that among the factors explored in the study (sociocultural factors, Economic factors, psychological factors and religious factors), the predominant factors that affected the attitude of male partners towards caesarean section are mainly economic factor or psychological factors. Fathers of children have an irrational fear of caesarean section as a life-threatening procedure. This fear maybe because of their limited knowledge of the procedure, or from stories of failed caesarean sections. Another factor is the cost of caesarean section. Many men who are liberal and are not scared of the procedure do not still subscribe to it because of the price. The study also affirms that fathers are as averse to cesarean section as mothers and this is greatly influenced by their fear of the procedure and their economic status

5.3 Recommendations

The following recommendations are made based on the findings of this study

1. Fathers and potential fathers should be the target of the reproductive health programme. A special session should be specifically organised for men whose wives are to undergo caesarean section, to teach them more about caesarean section. This will enable men to make informed decisions when it comes to the best choices for their wives and children.
2. There should be deliberate and extensive healthcare policies that encourage men to participate in women reproductive and sexual health. This male participation will, in the long run, dispel the fear men have about caesarean section and change their attitudes towards the procedure.

3. Further research should be done in this area to explore the prevalence of men who actually support their wives to undergo caesarean section in Nigerian and the after-effects of not supporting caesarean section even when it is important. Further research can also be done for the best intervention to be carried out for the behavioural and attitudinal change of men towards caesarean section.

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APPENDIX I

INFORMED CONSENT FORM

Dear respondent,

My name is Oboijagbe Favour,I am a postgraduate student from the department of health promotion and education, faculty of public health, University of Ibadan. I am conducting a study with the purpose of investigating the knowledge and attitude of male partners towards caesarean section in Ibadan north local government area, Ibadan, Oyo state.

Title of the research:

Knowledge and Attitude of Male Partners towards Caesarean Section in Ibadan North Local Government Area, Ibadan, Oyo State**.**

Name(s) and affiliation(s) of researcher(s) of applicant(s):

This study is being conducted by **OBOIJAGBE FAVOUR** from the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Oyo State.

Purpose(s) of research:

The research is aimed at investigating the knowledge and attitude of male partner towards caesarean section in Ibadan north local government area, Ibadan, Oyo state**.**

Procedure of the research.

Multi-stage sampling technique will be applied in selecting the 323 study participants needed for this study. The participants will be from 12 communities in Ibadan north local government. The study will adopt a quantitative method, with a structured and interviewer-administered questionnaire for data collection. The questionnaire will assess the knowledge of caesarean section, attitude towards caesarean section and the factors that affect the attitudes. Information given will be kept confidential and only the principal investigator and research assistants will have access to such data. The study will require the participant to provide adequate and honest information.

Expected duration of research and of participant(s)' involvement:

The duration for this data collection is 2 weeks. The study will require a maximum duration of about 15 minutes of your time to fill the questionnaire.

Risk(s):

There will be no risks involved in this study as you will be tagged anonymous and private information will not be taken.

Costs to the participants, if any, of joining the research:

Your participation will only cost the little time required to provide relevant information.

Beneficence

The result of this study has no direct benefit to the participants. However, it will help policymakers and other health researchers to develop effective interventions that will ensure that male partners are carried along in women's reproductive health and that they support caesarean section as a strategy to reduce maternal mortality. It will also set a foundation for further research to make recommendations on how to change the attitudes of male partners towards caesarean section

Confidentiality:

No private information such as name and phone number etc. is required by the investigator. Further privacy will be ensured by using serial numbers instead of names. Research assistants would be trained on the importance of confidentiality. Information collected from the participants will be kept confidential and all data will be kept under lock and assessed by only authorized individuals.

Non-maleficence

The researcher will ensure that no harm comes to the research participants as a result of this research.

Voluntariness:

Participation in this study is strictly voluntary. Participants may choose to withdraw from the study at any time.

Alternatives to participation:

Your non-participation will not affect you in any way.

Consequences of participant's decision to withdraw from research and procedure for orderly termination of participation:

You may choose to withdraw from the research at any time. Please note that some of the information that has been obtained about you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However, the researchers promise to make an effort in good faith to comply with your wishes as much as is practicable.

Ethical considerations

Ethical considerations will be sought from the Oyo State Ethics Review Committee.

Statement of the person obtaining informed consent:

I have fully explained this research to…….. And have given sufficient information, including risks and benefits to make an informed decision.

DATE……. SIGNATURE…….

NAME…….

Statement of the person giving consent:

I have read the description of the research and had it translated into the language I understand. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE……. SIGNATURE…….

NAME……

Detailed contact information including contact address, telephone, fax, email and other contact information of researcher(s), institutional HREC and head of the institution:

The research has been approved by the Oyo state Ethics Committee, Ministry of Health, Oyo state secretariat, Ibadan

In addition, if you have any question about your participation in this research, you can contact the principal investigator,

Name……..

Department……Phone……

Email……

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT

KNOWLEDGE AND ATTITUDE OF MALE PARTNERS TOWARDS CAESAREAN SECTION IN IBADAN NORTH LOCAL GOVERNMENT AREA

QUESTIONNAIRE

Dear respondent,

I am a postgraduate student from the University of Ibadan, at the department of health promotion and education, faculty of public health. The purpose of this study is to investigate the KNOWLEDGE AND ATTITUDE OF MALE PARTNERS TOWARDS CAESAREAN SECTION IN IBADAN NORTH LOCAL GOVERNMENT AREA. This study is aimed at covering the knowledge gap in this area.

It is important to understand that your participation in this study is completely voluntary and you can choose not to continue at any stage of the study. This questionnaire has been drafted in such a way as to ensure individual's identities are concealed and information gathered will be treated with the utmost confidentiality. Please feel free to respond as there is no right or wrong answer. Completing this questionnaire implies your consent to participate. **Please answer all questions as honestly and accurately as you can**

Thank you for your cooperation

Respondent's signature_____ Serial number_____

Section A: SOCIODEMOGRAPHIC INFORMATION

Kindly respond by ticking in the appropriate space

1. Age at last birthday (years) _____
2. Ethnicity: 1=Yoruba 2=Hausa 3=Igbo 4=Others
3. Educational level: 1=None 2=Primary 3=Secondary 4=Tertiary 5=others(specify)
4. Occupation: 1= artisans 2=civil servants 3=self-employed 4=trader 5= unemployed 6=others(specify)
5. Religion: 1= Christianity 2=Islam 3=Traditionalist 4=Others(specify)

6. Marital status: 1=single 2=married 3=divorced 4=separated

7. If married, type of marriage: 1=polygamy 2=monogamy 3=others

8. Average monthly income: _____

9. Number of children _____

Section B: KNOWLEDGE OF CAESAREAN SECTION (tick all options that apply)

10. Have you heard about caesarean section? 1=Yes 2=No

11. A caesarean section is done by cutting a woman's abdomen 1=Yes 2=No

12. A procedure to remove a tumor is called a caesarean section too 1=Yes 2=No

13. Caesarean section can also be by choice 1= Yes 2=No

14. The following can happen during a caesarean section EXCEPT

    1. stitching
    2. removal of baby
    3. use of analgesic
    4. bleeding
    5. sweet sensation

15. Which of the following is right concerning women that can undergo a caesarean section?

    1. only younger women
    2. only age-advanced women
    3. only women with birth complications
    4. any woman

16. What are the medical reasons for a caesarean section that you know

		1=Yes	2=No
I	Breech presentation of the baby		
ii	Overweight child		
iii	Fear of labour pain		
iv	Fear of death		
V	Previous caesarean section		
vi	Multiple babies		

17. Who can benefit most from a caesarean section

1. Mother
2. Family
3. The doctor

18. Which of the following is a clinical complication that can arise due to a caesarean section

		1=Yes	2=No
i	Death		
ii	Depression		
iii	Bleeding		
iv	Malaria		
v	Mental problems		
vi	Infections		

SECTION C: ATTITUDE TOWARDS CAESAREAN SECTION

Kindly tick if you agree or disagree with the following variables or are undecided

S/N	VARIABLES	AGREE	UNDECIDED	DISAGREE
19	I consider caesarean section as a good thing			
20	I can support my wife's decision to give birth through a caesarean section			
21	I believe only women with complications should go through caesarean section			
22	I consider caesarean section as a procedure meant only for people of high social class			
23	I am of the opinion that people hardly survive caesarean sections			
24	I believe that caesarean section can limit the number of children a woman can have			
25	I believe a woman should have control over her mode of delivery			

26	I will only accept caesarean section as a last resort			
27	I believe caesarean sections cannot be performed without complications			
28	I think caesarean section should be banned			

SECTION D: FACTORS AFFECTING THE CHOICE FOR CAESAREAN SECTION

ECONOMIC FACTORS

S/N	VARIABLES	YES	NO
29	caesarean sections are too expensive		
30	High costs of caesarean sections discourage its use		
31	Many people cannot afford a caesarean section even if it is necessary		
32	People will consider a caesarean section if the price is reduced		

SOCIOCULTURAL FACTORS

S/N	VARIABLES	YES	NO
33	Caesarean section is a taboo in my culture		
34	A woman does not attain motherhood if she undergoes a caesarean section		
35	Anyone that has had a caesarean section cannot have a normal vagina delivery again		
36	Caesarean section is not in line with our culture		
37	Having a caesarean section may reduce a woman's sexual function		
38	Caesarean section means a woman is weak		
39	Caesarean section destroys a woman's body		
40	My family members will go against caesarean section		

PSYCHOLOGICAL FACTORS

S/N	VARIABLES	YES	NO
41	caesarean section can lead to the breakup of a marriage		
42	Caesarean sections are very dangerous		
43	A child can die if birthed through a caesarean section		
44	A woman can die if she goes through a caesarean section		
45	Babies from a caesarean section do not live long		

RELIGIOUS FACTORS

S/N	VARIABLES	YES	NO
46	Caesarean section is against my religious beliefs		
47	Caesarean section undermines divine power		
48	Caesarean section should be forsaken if a pastor/imam advises against it		
49	Caesarean section is as a result of supernatural forces		
50	Children are a gift from God and caesarean section negates that		

ÌLÀNÀ FÚN ÀSẸ

IMO ATI IWA TI AWON ALABASEPO OKUNRIN SI ONA ISE ABE NI IJOBA IBILE IBADAN NORTH, ILU IBADAN, IPINLE OYO, NI ORILEDE NIGERIA

Ẹyin Olùkópa wa Owọn,

Mo jẹ akẹ̀ẹ́kọ́ làtí ile ìwé giga Yunifàsitì tí Ilẹ Ibádán ni ẹka tí àtí n risi eto nípa idanilẹkọọ ati igbega eto ilera, ti o wan i Kolẹẹji tí ati n se itọju pélu oogun, ni abala tí ohun risi eto ilera àwọn ara ilu. Idi ti iwadi yii ni lati se iwadi awon imo ati iwa ti awon alabasepo okunrin si ona Ise abe ni ijoba ibile Ibadan North, ilu ibadan, ipinle oyo, ni orilede Nigeria. Kikopa nínú iwadi yìí jẹ tí eyi ti oti okan yin wa, ati fi ohunka idanimọ si ara awọn iwe ibeere kookan lati dabobo idanimọ yin. Gbogbo àlàyé tí ẹba si se fún mi ninu iwadi yi ni yìí o wa ni ipamọ larin emi àtí ẹyìín, mi ko sini se afihan rẹ fún ẹnikẹni.

Kikopa yin ninu iwadi yii ṣe pataki pupọ nitoriwipe yi o ṣe iranlọwọ fun oluwadi lati mọ iriri awọn iya ọmọde nipa irẹwẹsi lẹyin ibimọ ati biwọn se hun se ifarada rẹ. Ẹ jọwọ ẹni lati ṣe akiyesi wipe ko si idahun ti o tọ tabi eyi ti kotọ ninu gbogbo idahun eyikeyi ti ẹba fi esi si awọn ibeere ti a ba bi yin. Didahun si awọn ibeere yi ko ni gbayin ni akoko pupọ, nitoriwipe ko ni gbayin ju ogun tabi ogbọn iṣẹju lọ. Ki a to maa tẹ siwaju, o tunmọ siwipe ẹ ti fi aramọ lati kopa ninu iwadi yi pẹlu gbigba lati kopa ninu ifọrọwanilẹnuwo.

A dupẹ lọwọ yin fun ifowọsowọpọ yin.

Ohunka Idanimọ_____

ÌLÀNÀ IWE-IBEERE

Idanimọ_____

Ẹ jowo, ẹ se àlàyé tí o ba péye, ti o si je otitọ fún mi lori awọn ibeere wọn yi – eleyi se pataki pupọ.

IPIN KINI: ÀLÀYÉ LORI ETO IGBESIAYE OLÙKÓPA

1. Ọjọ ori ni yin igba ti ẹ se ọjọ ibi yin kẹhin (ni ọdun)_____

2. Kíni eya tí ẹ tíwa? 1= Yoruba 2= Igbo 3= Hausa 4= Awọn ẹlomiran_____
3. Ipele eko 1= Mi o kawe 2 = Eko alakobere 3= Ile ìwé girama 4= Ile ìwé giga 5=awon elomiran_____
4. Ise wo ni e n se 1=ise owo 2=osise ijoba 3= ise ti ara eni 4=onisowo 5= Mi o sise 6= awon elomiran_____
5. Kíni ẹsin tí e n sin 1= Kristiani 2= Musulumi 3= Ibile 4= Awọn ẹlomiran _____
6. Kíni ipo igbeyawo yìín? 1= Mo ti gbeyawo 2= Mi o ti gbeyawo 3= Mo tí ko oko/iyawo mi silẹ 4= Emi ati oko/iyawo mi ti pinya
7. Ti e ba ti gbeyawo, kini ipo igbeyawo yin? 1= oniyawo pupo 2=oniyawo kan 3=awon elomiran_____
8. Apapo owo yin losoosu _____(e so ni pato)
9. Iyen omi ti e bi _____ (e so ni pato)

IPIN KEJI: IMO NIPA ISE ABE (FI AMI SI GBOGBO AWON ASAYAN TI O WAYE)

10. Ise abe le fa isiro kan
    1= beeni 2= rara
11. Ise abe ti se lori ikun obirin
    1= beeni 2 = rara
12. Ilana kan lati yo kuro tumo ye ise abe
    1=beeni 2=rara
13. Ise abe le tun ye nipa asayan
    1=beeni 2=rara
14. Nkan wonyi le sele lakoko ise abe, AYAFI
    1. aranpo/pa asoke
    2. imukuro ti omo
    3. lilo ti awon oogun ti ajeku
    4. eje
    5. dun ti o dun

15.Eyi ti awon wonyi je otito nipa awon obirin ti o fagbara ise abe

1. awon odobirin nikan
2. awon obirin agbalagba nikan
3. awon obirin nikan pelu awon idibi ibi
4. eyikeyi obirin

16. Kini awon idi iwosan fun ise abe ti o mo

		1= beeni	2= rara
1	Breech fifihan omo		
2	Omo apoju/ omo nla		
3	Irora ti laala		
4	Iberu iku		
5	Isaaju ise abe		
6	Opo omo		

17. Awon eniyan wonyi le ni anfaani lati ise abe

1. iya
2. omo
3. dokita

18. Yan awon isoro egbodi ti o le sele lati ise abe

		1=beeni	2= rara
I	Iku		
Ii	Suga		
Iii	Eje		
Iv	Ibaje		
V	Isinwin		
Vi	Ikolu		

19. **IPIN KETA: IWOYE NIPA ISE ABE**

	Ibeere	gba	O mo	Ko gba
1	Mo ro ise abe bi ohun rere			

2	Mo le se atileyin fun iyawo mi lati se ise abe			
3	Mo gbagbo nikan awon obirin pelu isoro nigba ibimo ye ki o se ise abe			
4	Mo ro caesarean bi a se so fun awon eniyan ti o ga julo			
5	Mo wa ninu ero pe awon obirin ko ni ewu ninu ise abe			
6	Mo gbagbo ise abe le dekun nomba awon omo ti obirin le ni			
7	Mo gbagbo pe obirin ye ki o ni isakoso lori ifijise re			
8	Mo yoo gba ise abe nikan gegebi ohun asegbeyin			
9	Mo gbagbo ise abe ko see se laisi awon isoro			

IPIN KERIN: AWO OKUNFA FUN ISE ABE

20. Aje ifosiwewe

	IBEERE	BEENI	RARA
1	Ise abe ju owo lo		
3	Iye owo giga ti ise abe se idiwo lilo re		
4	Emi ko le mu ise abe paapaa ti o je dandan		
5	Emi yoo se ayewo ise abe ti o bat i din owo naa dinku		

21. Awon okunfa to je mo asa ati ise.

	Ibeere	BEENI	RARA
1	Ise abe je iduro ni asa mi		
2	Obirin kan ko ni itoju iya si ti o ba je ise abe		
3	Enikeni ti o ni ise abe ko le ni awon ifijise deede siwaju sii		
4	Ise abe kii se ila pelu asa wa		
5	Nini ise abe dinku ise isinmi obirin		

6	Ise abe tumo si pe obirin ko lagbara		
7	Ise abe n pa arabirin kan run		

22. Awon ifosiwewe inu

	Ibeere	BEENI	RARA
1	Ise abe le ja si adehun igbeyawo		
2	Awon ise abe je ewu pupo		
3	Awon omo ikoko le maa ku nipase ise abe		
4	Obirin kan le ku bi o ba je pe o je olutoju ise abe kan		
5	Awon omo ikoko lati ise abe kii gbe si agbalagba		

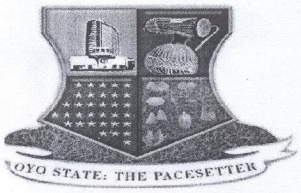
23. Awon okunfa to jo mo esin

		BEENI	RARA
1	Ise abe lodi si awon igbagbo esin mi		
2	Ise abe n ba agbara ibawi je		
3	Ise abe ko ye ki o se ti o ba je pe aguntan tabi imam waasu su i		
4	Ise abe so pea won omo je ebun lati odo olohun		

APPENDIX 4

ETHICAL APPROVAL LETTER

TELEGRAMS…….. TELEPHONE……..



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. ……..
All communications should be addressed to
the Honorable Commissioner quoting
Our Ref. No.AD 13/479/1401

15th August, 2019

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Oboijagbe Favour

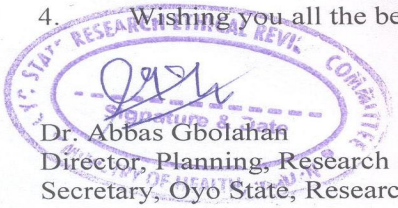
ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Knowledge and Attitude of Male Partners towards Caesarean Section in Ibadan North Local Government Area, Ibadan, Oyo State." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.



Signature & Date

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee