

**KNOWLEDGE AND ATTITUDE TOWARDS HAVING CAESAREAN SECTION
DELIVERY AMONG ERITREAN COMMUNITY IN KAMPALA, LUBAGA DIVISION**

YORSALIEM GEBREGZIABIHER TEFAY

2011-BNS-FT-025

**AN UNDERGRADUATE RESEARCH DISSERTATION SUBMITTED TO THE SCHOOL
OF NURSING IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
AWARD OF A BACHELOR'S DEGREE IN NURSING OF
INTERNATIONAL HEALTH SCIENCES UNIVERSITY**

AUGUST, 2016

DECLARATION

I, Yorsaliem Gebregziabihher Tesfay declare that this research proposal is my own original work and has not been submitted for any award of degree by any other person or university. There is a complete reference to all the sources of information used in the proposal.

Signature.....

YORSALIEM GEBREGZIABIHER TEFAY (STUDENT)

Date

APPROVAL

This is to declare that this research proposal has been conducted under my supervision and assistance and is submitted to the University with my approval.

Signature.....

MRS. WANYENZE EVA (SUPERVISOR)

Date.....

DEDICATION

I whole heartedly dedicate this work to my family who worked hand in hand with me to lay my education foundation from my first day in school up to what I am today. Thank you for guiding me through all walks of my life.

ACKNOWLEDGEMENT

The successful development of this proposal involved the support and contribution of several individuals. Above all I praise God, the Almighty for providing me the strength, courage, determination and hope in times when it seemed to be impossible and difficult, to finish my study as well as guidance in conducting this research study.

I would like to convey my sincere gratitude to my family members. My brother Michael and his family, my mother as well as my brothers and sisters who have given me support both emotionally and financially. I would also like to thank them for their support, encouragement and wise advice throughout my studies. Especial thanks to my brother Michael for supporting me financially and my brother Rezene for all his hard work in helping me during my whole studies.

Humbly wish to submit and extend my sincere appreciation and abundant thanks to the lecturers of International Health Sciences University for their encouragement and guidance throughout the programme. Especial thanks to Mrs. Wanyenze Eva, my supervisor who has always been there for me in returning chapter drafts with perceptive comments and also for her support and punctuality.

I wish to extend my appreciation to my colleagues for standing by me during my studies. My research assistant Senait Tekie for willingly cooperating and successfully executing the data collection exercise. Thanks a lot to the entire Eritrean community in Kampala especially those in Lubaga division for their participation and cooperation during the data collection process.

TABLE OF CONTENTS

DECLARATION	i
APPROVAL	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
TABLE OF CONTENTS	v
LIST OF FIGURES	x
LIST OF TABLES	xi
OPERATIONAL DEFINITION	xii
LIST OF ACRONYMS	xiii
ABSTRACT	xiv
CHAPTER ONE	1
1.0 Background.....	1
1.1 Problem statement.....	3
1.2 Justification/Significance of the study.....	4
1.3 Objectives of the study.....	5
1.3.1 General objectives.....	5

1.3.2 Specific objectives.....	5
1.4 Research question.....	5
1.5 Conceptual framework.....	6
CHAPTER TWO: LITERATURE REVIEW	7
2.0 Introduction.....	7
2.1 Overview.....	7
2.2 Knowledge regarding CS delivery.....	8
2.3 Attitude towards CS delivery.....	10
CHAPTER THREE: METHODOLOGY.....	17
3.1 Introduction.....	17
3.2 Study design.....	17
3.3 Sources of data.....	17
3.4 Study population.....	17
3.5 Study area/setting.....	18
3.6 Sample size calculation.....	18
3.7 Sampling procedures.....	19
3.8 Inclusion criteria.....	20

3.9 Exclusion criteria.....	20
3.10 Study variables.....	20
3.10.1 Dependent variables.....	20
3.10.2 Independent variables.....	20
3.11 Data collection techniques.....	21
3.12 Data collection tool.....	21
3.13 Data management.....	21
3.14 Plan for data analysis.....	22
3.15 Quality control issues.....	22
3.16 Ethical issues.....	22
3.17 Plan for dissemination.....	23
CHAPTER FOUR: RESULTS.....	24
4.0 Introduction.....	24
4.1 Proportion of those who had CS or their wives among the respondents	24
4.2 Demographic characteristic of the respondents.....	25
4.3 Knowledge factors of the respondents.....	27
4.3.1 Awareness about CS	27

4.3.2 Indication for CS.....	27
4.3.3 Knowledge regarding CS.....	28
4.3.4 Knowledge regarding recovery from CS.....	29
4.4 Attitude of the respondents towards CS.....	30
CHAPTER FIVE: DISCUSSION.....	33
5.0 Introduction.....	33
5.1 Proportion of CS among Eritrean women.....	33
5.2 Knowledge of the respondents on CS.....	33
5.3 Attitude of the respondents towards CS	35
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS.....	40
6.0 Introduction.....	40
6.1 Conclusion	40
6.2 Recommendation.....	41
6.2.1 Community leader.....	41
6.2.2 Health workers.....	41
6.2.3 Policy makers.....	42
REFERENCES.....	43
APPENDIX I: Consent form.....	47

APPENDIX II: Questionnaire.....	49
Part I: Social demographic.....	49
Part II: Knowledge on caesarean section.....	49
Part III: Attitude on caesarean section.....	51
Proposed Budget.....	53
Work plan.....	54
APPENDIX III: Introductory Letter.....	52
APPENDIX IV: Correspondence.....	53

LISTS OF FIGURES

Figure 1: Showing proportion of CS.....	25
Figure 2: Showing indication for CS	28
Figure 3: Showing respondents' Knowledge regarding CS.....	29
Figure 4: Showing Knowledge of recovery from CS.....	30

LIST OF TABLES

Table 1: Showing the demographic characteristic of the respondents.....	25
Table 2: Showing respondents awareness about CS.....	27
Table 3: showing attitude of the respondents towards CS.....	31

OPERATIONAL DEFINITIONS

Attitude: The ways you think or feel about something or someone; a feeling or way of thinking that affect person behaviors.

Caesarean section: operative surgical procedure worldwide where fetus is delivered through an abdominal and uterine incision.

Knowledge: Are facts, information, and skills acquired by a person through experience or education, the theoretical or practical understanding of a subject.

Prevalence: is the proportion of a population who has (or had) a specific characteristics in a given time period.

Surgery: is a medical specialty that uses operative manual and instrumental techniques on a patient to investigate and/or treat pathological condition.

LIST OF ACRONYMS

ANC:	Antenatal clinic
CS:	Caesarean Section
DHS:	Demographic Health Survey
MDCS:	Maternal Demand for Cesarean Section
PPROM:	Prolonged premature rupture of membrane
UDHS:	Uganda Demographic Health Survey
UK:	United Kingdom
USA:	United State of America
WHO:	World Health Organization

ABSTRACT

The purpose of this study was to investigate the knowledge and attitude towards having Caesarean Section delivery among the Eritrean community leaving in Kampala, Lubaga division. The specific objectives of the study were: i) To establish the proportion of women who deliver by CS among Eritrean community in Kampala, Lubaga division, ii) To assess the level of knowledge regarding Caesarean Section delivery among Eritrean community in Kampala, Lubaga division and iii) To assess the attitude towards Caesarean Section delivery among Eritrean community in Kampala, Lubaga division.

A cross sectional descriptive study design was carried out in Lubaga division on both men and women aged 18-50. Primary data was collected using researchers administered questionnaires, a total of 80 respondents were sampled using convenience sampling technique.

For uni-variate analysis, data was run using frequencies and percentages, and the results presented in form of pie chart and tables.

The results indicated that 35 (43.8%) women and wife's of the men respondents had CS in their last delivery, almost eight in every ten of the respondents strongly disagreed that CS would be the preferred method of delivery although they had a good knowledge on the indications and recovery of CS.

Based on these findings, the study recommends that health care workers should give a complete information on CS during the ANC and pregnancy so this will allow couples to make informed decision about the health of the mother during pregnancy and delivery through CS. And health

workers should allow and encourage women to have a normal deliveries and whenever indicated it should be done quickly to save both lives

CHAPTER ONE

1.0 Background

Caesarean Section (CS) has been part of human culture since ancient times both in the Western and non-Western cultures (U.S. National Library of Medicine, 2013).

CS is a common operative surgical procedure worldwide, where by a mother delivers her fetus surgically through the abdomen by making an incision on the uterus. Maternal or Fetus related complications can be indications for this operation. Over the past number of years the proportion of women delivering through CS has increased in all developed countries. (Qazi et al, 2013).

In 1998, globally the following countries were having the following percentages 21% of Australian women gave birth by CS and it increased to 30.9% by 2007. And 31.1% of all births were carried by CS in 2006 in the USA. In the UK the overall rate of CS birth accounts for almost 25% of all births from 2007 to 2008, Birth rates via CS vary considerably across Europe, ranging from 15% in Norway and Netherlands, 17% in Sweden and Finland and 37.8% in Italy. Because of the negative view and perception of CS by women in developing countries the rate is small example in the Sub-Saharan African Countries (like Burkina Faso and Niger) it is 2%. (Qazi et al, 2013).

However women in the developed countries accept CS because they have a better understanding of its role and safety. In contrast, a number of reports indicated that women in many sub Saharan African countries are reluctant to agree to have CS deliveries. Recent study done in West Africa reported that CS is not been practiced when it is compared to the huge load of obstetric morbidity that is needed to be resolved by CS The elevated number or rates of prenatal and maternal

morbidity in the African countries is recognized to be because of the insufficient practice of early CS (Aziken et al, 2007).

In countries like Burkina Faso and Niger the CS percentage is very small that it is only two percent and this is because of the women's negative view and lack of awareness towards CS. (Qazi et al, 2013).

Majority of the women in the study conducted in Ghana preferred vaginal delivery even though they had high awareness of CS as an alternative to vaginal delivery. The attitudes towards CS were positive if the operation is indicated. (Adegbeba et al, 2008).

According to Uganda Demographic Health Survey (DHS) conducted in Uganda in 2006, less than 50 % of births within Uganda in the five years preceding the survey took place in health facilities and of those delivering at various health facilities, 3% of births were delivered by CS due to obstructed labor, Cephalo pelvic disproportion, Pre-Eclampsia and Eclampsia. Additionally when viewing the utilization of CS by sub regions of Uganda the DHS showed the prevalence of CS varied from a high of 4% in Western area, which includes Mbarara to a low of 1.5% in Northern part (Natasha Spencer, 2015). A study done in 2011 found that it has risen up to 5.22%, the increase in CS prevalence in Uganda is also involving the Eritrean community that are living in the same community as Ugandans meaning that the 5.22% rise also includes Eritreans living in Uganda.

Among Eritrean Community living in Uganda of 100,000 most of which live in Kampala, 8.1% of the women were found to have gone through CS in their last deliveries (Eritrean Embassy).

1.1 Problem Statement

Women are traditionally unwilling to have CS because of the general belief that abdominal delivery is reproductive failure on their part regardless of the feasibility of vaginal birth after CS and the decreasing mortality from CS (Jeremiah I et al, 2011).

CS can be life saving procedure in conditions such as Cephalo-pelvic disproportion, Uterine rupture, Obstructed labour, Breech presentation, Pre-eclampsia and Eclampsia which if not performed mothers and babies face serious problems such as; fetal distress, infections, uterine rupture, postpartum hemorrhage and other birth injuries. In Uganda because CS is not considered 22% and 10% of mothers die due to obstructed labour and Ruptured uterus respectively (Kabakyenga et al, 2012).

According to WHO 2012 maternal death and disability due to hemorrhage and obstructed labour may be averted by timely CS, access to CS will reduce maternal mortality in low significant income countries (J. Meadows, 2012).

Even though women are sensitized on the safety and importance of this procedure many are still afraid of it. Most studies have been done elsewhere regarding knowledge and attitude of CS but little is known in regards to the knowledge and attitude of CS among Eritrean Community in Kampala, Uganda. Some Eritrean women living in Kampala go through difficult labor because the couples think that the women can deliver normally and because of the delay in CS they go through so much pain and still do CS because it is required. Sometimes there are some men who put their women in to psychological stress and feeling unworthy when they take long to decide for CS even though the woman agrees to do it. Some women also delay and because of the

delays to undergo CS when recommended, these Eritrean mothers get complications such as; Ruptured Uterus, Fistula, Excessive bleeding and some mothers lost their lives and lives of their babies. And Some couples decides to move from facilities to facility in search for normal delivery, thus this mothers get complications on the way putting their lives and the lives of their baby at risk.

This study is aimed in establishing the proportion of CS deliveries and to assess the knowledge and attitude of the Eritrean community in Kampala regarding CS Delivery.

1.2 Justification/Significance of the study

This study aimed at finding out what is known about CS and the reasons for murmuring and delaying the procedure by the community when it is indicated. The findings from this study could be used in planning strategies in improving the Knowledge and attitude towards CS in the community in order to possibly reduce the delay in presentation to the health facility when CS is needed, improve utilization of this mode of delivery and limit the avoidable maternal and fetal complications and death. Midwives in practice also should change their attitude toward CS and vaginal delivery and help pregnant women to make the right decision. The research may also affect the educational policy to focus on this topic and teach nursing students plus midwives on how to teach different communities and cultures about the advantages and disadvantages of CS and also educate them about the consequences of delayed or not going through CS when needed. As a last point the study should also be useful source of reference for other researchers and readers in general by providing them more knowledge and literature search.

1.3 Objectives of the study

1.3.1 General objectives

The general objective of the study was to establish the proportion of women who deliver by CS and also to assess the level of knowledge and attitude towards having CS delivery, among Eritrean community in Kampala, Lubaga division.

1.3.2 Specific objectives

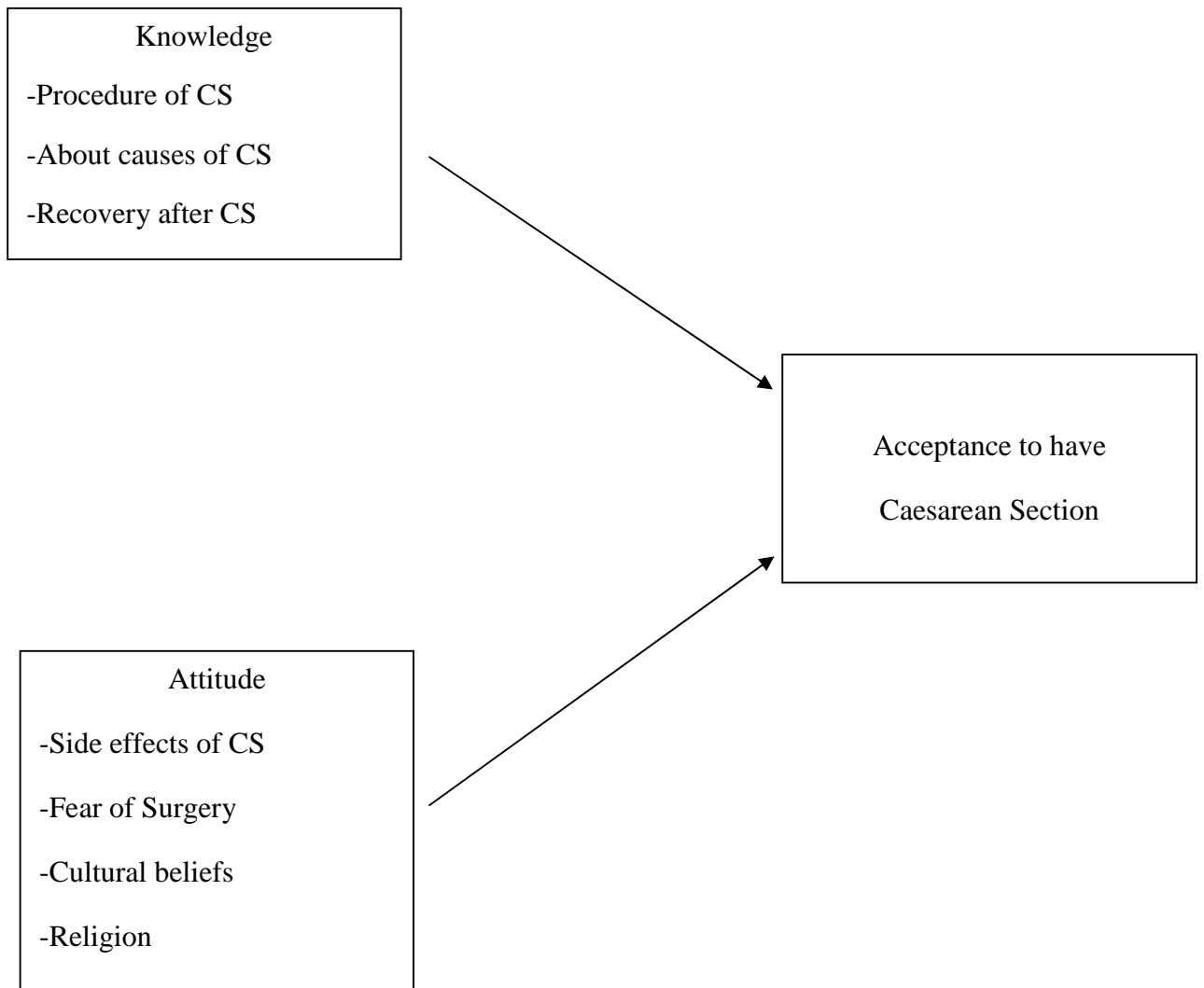
- i. To establish the proportion of women who deliver by CS among Eritrean community in Kampala, Lubaga division.
- ii. To assess the level of knowledge regarding Caesarean Section delivery among Eritrean community in Kampala, Lubaga division.
- iii. To assess the attitude towards Caesarean Section delivery among Eritrean community in Kampala, Lubaga division.

1.4 Research Question

- i. What is the proportion of women who deliver by CS among Eritrean community in Kampala, Lubaga division?
- ii. What is the level of knowledge towards Caesarean Section delivery among Eritrean community in Kampala, Lubaga division?
- iii. What are the attitudes towards Caesarean Section delivery among Eritrean community in Kampala, Lubaga division?

1.5 Conceptual framework

CONCEPTUAL FRAMEWORK



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter will present the literature review of topic under study. It is arranged under different subsections of the study which includes knowledge and attitude of Caesarean Section delivery.

2.1 Overview

Pregnancy and delivery are considered as normal physiological phenomenon in women. Approximately, 10% of deliveries are considered to be as high risk, some of which may require CS. Modern CS was first performed by a German gynecologist Ferdinand Adolf Keher in 1881.

CS normally is carried out when the normal way of delivery (vaginal delivery) will put both the mother's and baby's life at risk, but sometimes mothers request for it even when there is no risk at all. In recent years different studies show the rate has risen in different countries. In China by 46% and 25% or above in many Asian and European countries, Latin America and USA. Nowadays CS is common surgical operation for delivering one or more babies, prevalence ranges from 4% in Africa to 29% in Latin America and Caribbean (Maimoona and colleagues, 2014).

Some of the indications for CS delivery include; Repeated CS delivery, Pelvic abnormalities, Malpresentations, skeletal disorders, abnormal placentation, Cephalopelvic disproportion, Situations in which labor is contraindicated.

2.2 Knowledge regarding CS delivery

According to a descriptive and cross sectional study done by (Ashimi et al, 2013) 409 pregnant women were approached to participate; those women were attending the antenatal clinic in Federal Medical Centre Birnin Kudu, a tertiary institution located in a semi-urban setting in Jigawa state, northwest Nigeria. In the study majority 376(93.8%) of them were aware and had heard about CS out of this women 32(8.5%) had delivered and practiced it. Their knowledge towards the procedure of CS was high, 325 out of 376 were aware that transfusion of blood during or after the procedure may be required. In the same study 244 (64.9%) and 237 (63.0%) out of 376 respondents known that prolonged labour due to big baby and bleeding per vaginam before delivery are some of the indications for CS. While 15(14.6 %) did not know how long is needed to stay in the hospital after the procedure the rest 274(72.8%) have a very good knowledge about the recovery or hospital stay after the procedure, which is normally only a week or less. When they were interviewed 355(94.4%) of them said they know that vaginal delivery is possible after CS delivery. However, although majority of the women surveyed were aware and would accept to have CS if indicated, knowledge about CS is still low in the setting. The need for birth awareness and complication readiness with the involvement of men is vital in influencing or changing the perception of women in this setting towards CS (Ashimi et al, 2013).

Similarly a study carried out by RK Adageba et al, in an Antenatal clinic (ANC) in Komfo Anokye Teaching Hospital (KATH), Kumasi Ghana in 2006, However in this study all the pregnant women who were taken on for the study were women who had never had any previous CS deliveries. The study used descriptive cross-sectional design and there were 317 pregnant respondents during the one month period, and from the results obtained or found 304 (96%) had

already heard about CS while 13 (4%) had never heard about CS. From those who heard about CS the 70 (23%) of them heard from one source while 234 (77%) heard from various sources; such as health workers, media, family etc. The commonest sources of information for these women were the health workers 34.4% of them heard it from health workers, where as the 26.5% heard from relatives and the remaining 20.8% heard about CS delivery from the media. From the participants only (13.5%) that is 43 clients had knowledge about the indications of CS and can actually state some but the given once where: the cervix unable to open, big baby, baby not lying well and mother too ill (Adageba et al, 2006).

Also in a study done in the Urban of Nigeria, although they had good knowledge about delivering through operation just 6.1% were accepting CS as a way of bringing their babies to the world, however 81% said they will be willing to go through it if it is indicated and will save both the lives and the remaining percentage said that they would not have it even if it costs the lives. (Aziken et al, 2007).

In Tehran Iran, Fatemeh G. et al made a study in 2012 it was a study done on women's knowledge and attitude towards mode of delivery and frequency of CS on mother's request in six public and private hospitals. The knowledge of the mothers was overall attained poor score in 333 (55.6%) and 228 (37.9%) found out to score intermediate while 39 (6.5%) attained good scores on their knowledge towards the mode delivery. And mothers who have old age were found to have higher level of knowledge (Fatemeh G., et al., 2012). Similar results were found in a study done by Nusrat N., Nisar A. and Ahson M. to know the knowledge of antenatal clinic attending mothers. It was a KAP (knowledge, attitude and practice) study done in Antenatal clinic of Obstetrics and Gynecology Department at Isra University Hyderabad Sindh, 2007 -

2008. During the study 446 women attending the antenatal were interviewed after obtaining informed consent from them. Depending on the results of this study the overall knowledge about modes of delivery was low. Only 7 (1.6%) got good knowledge, 47 (10.5%) got medium scores of knowledge whereas the rest 392 (87.9%) women have weak knowledge however, at all this three levels of knowledge mentioned most of the women showed positive attitude towards vaginal delivery. And this is thought to be that maybe it is the reflection of their traditional views about the normal child bearing process in the community. These findings also are almost similar to study from Iran (Nusrat Nisar, 2009).

2.3 Attitude towards CS delivery

To determine the attitude towards CS a study was done by Michael A., et al 2007, among antenatal women who come for care at the University of Benin Teaching Hospital in Nigeria, 413 successive women who came for the antenatal care were interviewed with a structured questionnaire. All the participant women reported that they have heard about CS from different sources. However, it was reported that all the women have heard about CS and out of four options given to them they were all able to identify that CS is a delivering a baby by operation through the abdomen. From the study population some women said that they would have CS by their own choice, their reason for choosing it was mainly fear of labor pain as well concerns about their baby's wellbeing this women add up to be 25(6.1%) of the study number. The majority number which is 338(81.8%) would accept CS if they know that the situation they are in will put their life or that of the baby's life at risk, while 246 (59.7%) say that they would allow it if the doctor said so. However, 50(12.1%) said that they would not accept CS under any of these 3 cases mentioned. Fear of death when having CS, pain after having CS that will be

associated with CS, concerns or feelings of failure, husband's disapproval, this mode of delivery as not being part of their culture, friends may laugh at them and the charge/price for the operation were some of the reasons given by the participants when asked about their refusal to CS. Other factors for their refusal were previous successful vaginal delivery, previous forceps usage and women not having had a previous CS. To gain further insights into attitudes about C.S. in the women, interviews were conducted with 5 women who were recovering from recent C.S. delivery that they went through in the hospital. At the time of discharge these women were asked on their experiences of CS. The reason stated by the women for going under that operation or to have C.S. were Cephalopelvic disproportion, Cord prolapsed, PPRM, distress of the fetal, eclampsia and placenta praevia (Michael A., et al 2007).

They all responded they have no option but to accept when a question was raised to them about future C.S. if requested. Their answer was as follows: one woman said 'I do not have any option, I will accept it because I understand that once you have done the operation once or twice, and there is a high probability for you to have it again'. Two other women said 'Normal delivery is good because it was ordained by God but with C.S, the pains from the stitches will be there and the constant fear of getting pregnant again, which will result in another CS, is there'. 'Delivery by operation is not bad, although people do frown at it' (Michael A. et al, 2007)

Similar results were found about the attitude of women in the study done by (Ashimi et al, 2013) a study which is already talk above, about the knowledge of CS among 401 women in Jigawa state, northwest Nigeria. Their answers to the likely hood of having repeated CS varying proportions of the respondents would pray not to have it, and some say they would discuss it with their husbands while others they would seek for help from religious leaders or traditional

birth attendants. Majority of the respondents (99%) were willing to have the procedure if indicated and 307(82%) would also have a repeat CS, but still about half of the respondents were not ready to undergo or have repeated CS reason being fear of dying and fear of pain. Women who delivered by CS were viewed as pathetic to 208 (55%) of the participants while, 123(33%) also viewed them as a weakling (Ashimi et al, 2013)

In another different study done by Kathrin S., et al, (2009) on men and women a cohort of 3,680 male and female students participated in the study. The samples were more often female (73% vs 56%). The students participated in an online survey of childbirth preferences and were also without any history of childbirth. The result showed that most men and women responded they preferred vaginal delivery, with 9 percent preference for CS delivery. Results indicate that a preference for CS is linked to fear of childbirth and driven by low confidence in vaginal birth.

First purpose behind both women's and men's inclination to vaginal deliveries highlighted that vaginal deliveries will be "Normal" and "natural" manner. It has been illustrated by remarks and comments from participants for example, "It is regular furthermore I might want me and my child to encounter it". And some saying "I think pregnancy may be a characteristic procedure and that deviating from nature when it may not be Important convolutes it further." Notable to the fundamental principle of "natural" was an opinion of safer method of delivery by both men and women, as it has less health problems and threats than CS for example, "My body was made for delivering naturally, and I think that I should rejoice its potential, rather than exposing it to unnecessary injury." Men's and women's arguments about vaginal delivery overlies with an obvious desire to prevent CS Further the motive for vaginal delivery preference included trepidation of cutting and a yearning to abstain from scarring in light of CS This apprehension

and shirking stands out from ladies' prominent "apprehension of vaginal delivery" as referred to in the publications and also the media. Fear of cutting and shirking of scarring might be identified with individual and social worries about the body, self-perception, and respectability, which surgery disrupts. Remarks, for example, "My wife won't be as appealing with a major scar on her tommy" and "Why make another opening for a child to leave at the point when there's one there as of now!" (Kathrin Stoll et al, 2009).

To explore the attitude of CS delivery among Somali immigrants in the USA a study was done by Maithri A. et al (2011), in this semi structured study an in-depth interviews were made to 23 Somali immigrants aged 25-52 years who live in Boston, these women had previously given birth in the USA and Africa. According to their results 15 women said that CS has never been discussed to them before when they were in Somali or even in refugee camps. While 10 said that they have heard but they were advised against it by friends, family members and other peers. Most of the women feared CS as it is a surgical procedure; they feared that it can cause death or permanent disability to them. They also perceived that after the operation recovery and activity of daily living such as lifting will be difficult. In general they believed that their body would never go back or return to its normal state. These women said that they were used to long labor in Africa however, in the USA they felt that they are not given enough time to labor, they are not given enough time they get pushed to do CS if did not deliver within a certain period of time and deliver through CS before they felt ready. Additional reason for these women to fear CS is that they did not get enough information and knowledge about CS during their prenatal visits in the USA even when they had little or no knowledge about it (Maithri A. et al, 2011).

A study was conducted among antenatal clinic attendants in a Ghanaian teaching hospital (Komfo Anokye Teaching Hospital, Kumasi, Ghana). This descriptive cross sectional study by R.K. Adageba et al 2008, was conducted to determine the awareness, perception and attitude of the pregnant women and 317 women were interviewed, out of the 317, 164 (51.7%) perceived that CS as a dangerous procedure for both the mother and baby however, the 94 of them which is (30.6%) felt that CS was not dangerous whereas, 56(17.7%) of them could not tell whether the operation is dangerous or not dangerous to the mother or baby. Some of the reasons that were perceived as dangerous bout CS by the 164 women was death of the mother (10), harm to the baby (30), post operative complications such as pain to the mother (120), loss of 'vitality' and strength (100) (R.K. Adageba, et al, 2008).

A structured questionnaire designed study was done in Yoruba among women of southwestern Nigeria, 2006. The study was done in a clinic among 300 pregnant clients attending their ANC. Still there is a perception in developing countries that women who undergo CS delivery are unfaithful and weak woman. In this study of Yoruba women, it was viewed with suspicion, aversion, misconception, fear, quilt, misery and anger. Therefore due to the negative perception CS is not chosen by many but very few choose it as a mode of delivery without any medical indications. In most of the sub-Saharan African countries including Nigeria women unwillingly agree to have CS even when there are obvious clinical indications. Since there were few participants on the attitude of women in Nigeria a study was made using a structured questionnaire among three hundred pregnant clients, it aimed at the evaluation of the attitude of women in Nigeria and their views of other women who have had C.S before. The women were attending antenatal clinic in Ebonyi State University Teaching Hospital, Abakaliki, Ebonyi state in Nigeria.

The study was required to obtain the personal perception of the clients about CS and it was graded using four grades as; Very good: they will accept CS by choice to avoid the complications of labour, labour pains and safety of the fetus. Good: Will allow CS if both lives are in great danger. Bad: Will unwillingly accept CS if the doctor says so Very bad: Will not accept CS under and circumstance. From the 300 questioners only 277 were fully completed and where used as a foundation for this study. Results from the current pregnancy showed that 225(81.2%) of the women said if the baby's life or their life is in danger then they say that CS is good, 4(1.4%) choose to do CS so to keep away from the pains and complication that arise from labor and vaginal delivery so they look at CS as very good, 34(12.3%) viewed it as bad and will go under unwillingly if the doctor said so and only 3 (1.1%) viewed CS as very bad and will go through it under any circumstances. In addition the cultural perception of the people of the participants was that 183(66.1%) see it is a normal obstetric decision. While 40(14.4%) see it as the failure of the women's obstetric responsibility and the remaining 4(1.4%) said that it is for cursed women (I Sunday-A., Kalu, 2011).

A cross-sectional study done in Nigeria, among 843 antenatal clients at Agbongbon/Orayan primary health care centers (PHCs), Adeoyo Maternity Hospital (SHC), and UCH Ibadan (THC) by Ngozi S, et al and they found out that the decision for maternal demand for cesarean section (MDCS) is very hard, because willingness is low and disapproval by partners of those who decide MDCS is high. But now since epidural anesthesia and improved safety of vaginal delivery this decision making for MDCS will not be hard based on fear of pain and poor labor outcome, thus vaginal delivery is recommended. As in this study the role of the male partner should be taken into consideration in order to make sustainable policies or guidelines for MDCS in developing countries. There is a lack of data showing why African women, in general association

vaginal delivery with successful womanhood, prefer to request cesarean section when vaginal delivery can be achieved. The first study on MDCS published from Nigeria and West Africa was done amongst southeastern Nigerian women who ask for MDCS between 2003 and 2006. In that study, 4.4% of all MDCS deliveries were due to the mother's request, reason been infertility in their previous years and also advanced maternal age. But, (85.2%) which is the majority said that to feel like "a real woman", they would like to practice normal vaginal delivery in their next pregnancy (Ngozi et al, 2012).

A self-administered questionnaire based survey was done in Women and Children Teaching Hospital Bannu, Pakistan, 2009. The respondents showed positive attitude to CS. And culturally, CS was linked to woman's failure of her obstetric responsibility. Death as a complication and postoperative pain after CS was also some of the respondents fear (Qudsia et al, 2009).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology that will be used in the research study. It gives a description of the study design, study area, study population, sampling methods, study variables, data collection, analysis and presentation, Reliability/validity of data and ethical considerations of the study.

3.2 Study design

This study was a cross sectional descriptive study that relied on quantitative methods of data collection. This design was chosen because data was collected at one point in time due to the time constraint. This study design has also been reported to be the most suitable for describing associations between variables and therefore informs decisions for further research (Given, Lisa, 2008).

3.3 Sources of data

The data was primary data which generated using well-structured questionnaire. Questionnaire allows large amounts of information to be collected from a large number of people in a short period of time and in a relatively cost effective way.

3.4 Study Population

The study population in this study will be Eritrean women and men age 18-50 living Lubaga division, this study also included men because there is a need to assess their knowledge and attitude as they are the critical deciders in the Eritrean community. And Lubaga division is selected because most Eritreans reside there.

3.5 Study area/setting

The study was carried out in Lubaga division one of the five divisions in Kampala. The division lies in the western part of the city bordering Wakiso district to the west and the south, the Eastern boundary is Kampala central division, Kawempe lies to the north.

3.6 Sample size calculation

The target population of 200 Eritreans who were eligible for the study are living in Lubaga division. Sample size estimation was based on Taro Yamane and Cochran's formulae. The sample size, n was calculated

$$n = \frac{N}{1 + N(e)^2}, \text{ where}$$

N = total number of Eritrean eligible for the study living in Lubaga division, Kampala

e = error or confidential level taken at 0.05

n = sample size

The population, N is 200 eligible Eritrean in living in Lubaga division based on the Eritrean embassy. Using the formula, the sample population was calculated using Yamane's (1967) formula

$$n = \frac{N}{1 + N(e)^2}$$

Given,

n = number of samples

N = number of total population

e = error, designation to be 0.05 significance level

$$n = 200 / [1 + 200 (0.05)^2]$$

$$n = 200 / 1.5$$

$$n = 133.33333$$

$$n = 133$$

The finite population and calculated sample is used in getting the p, the adjusted number of Eritreans that was studied using the Cochran's (1921) formula

$$p = n / [1 + (n-1)/N]$$

Where,

n=calculated sample size above

N=finite population

p=corrected sample size

$$p = 133 / [1 + (133-1)/200]$$

$$p = 132 / 1.66$$

$$p = 80.12$$

$$p = 80$$

Therefore 80 Eritrean will be studied

3.7 Sampling procedures

Convenience sampling method was used to enroll participants in the study. Where Any Eritrean man or woman in Lubaga was recruited consecutively until the study sample size was achieved.

This was because some of the Eritreans were not around and it was good to assess any Eritrean who was available at that time of data collection.

3.8 Inclusion criteria

- Eritrean community living in Kampala both women and men.
- Adult ages 18-50 years (Reproductive age)
- Who have had children

3.9 Exclusion criteria

Eritreans community both women and men who will be absent during data collection will be excluded from the study.

- Mentally ill
- Very Sick

3.10 Study variables

3.10.1 Dependent variables

Dependent variable in this study was acceptance to have caesarean section deliveries.

3.10.2 Independent variables

Knowledge of having caesarean section deliveries

- Procedure of caesarean section
- About causes of caesarean section
- Recovery after caesarean section

Attitude towards having caesarean section delivery

- Side effects of caesarean section

- Fear for surgery
- Cultural beliefs
- Religion
- Demonization by previous caesarean section

3.11 Data Collection techniques

Data was gathered through a researchers administered questionnaire to both men and women of Eritreans community. Research assistants were recruited and trained. The questionnaires were used to collect the primary information on, level of knowledge and attitude towards CS among Eritrean Community in Kampala. Each questionnaire was been checked for completeness to make sure if it was fully filled by the researcher assistant each day.

3.12 Data collection tool

The study used questionnaire as the main tool for gathering data on CS. The questionnaire was developed based on other studies and it constituted 3 sections; the first one is the Demographic characteristic of the respondent and the second one is the level of knowledge and the third one is attitude of the respondent towards CS delivery.

3.13 Data management

The questionnaires were been checked after they have been filled by the research assistants to ensure that there is no question left unanswered and then kept under key and lock. Data was then been coded to increase accuracy. Data was entered and analyzed using SPSS. A researcher's administered questionnaire was used to collect the required data from participants. Research tools were given to the participants that had both closed and open ended question. The researcher explained all the rights of the participants and then a statement of informed consent was obtained from the eligible participants. Participants were then allowed adequate time to fill in the

questionnaires. Those who were unable to read and write were interviewed and answers were written and circled for them while those who were able to write and understand it were handed the questionnaires to fill in.

3.14 Plan for data analysis

Questionnaires were cross checked at the conclusion of each day of data collection to make certain the correctness and completeness of the collected data. Data was then entered into a computer program, cleaned and also double entered to minimize errors. Data was then stored in a computer hard drive and a backup made on a flash drive. Thereafter, data was analyzed. Statistical tests of significance were performed including Pearson Chi square and regression analysis to identify variable relationships. Results were presented in tables and graphs.

3.15 Quality Control Issues

Data collection tools were checked for completeness and accuracy and stored safely after each field day.

- The questionnaire was pretested among Eritrean community in Entebbe.
- The questionnaire was explained during interview.

3.16 Ethical Issues

A letter of permission to carry out the study was sought from International Health Sciences University Research Department, where a letter of introduction was given to the researcher to introduce her to the appropriate office which is Lubaga division Kampala, Uganda. The division provided the researcher with a letter permitting the researcher to carry out the research. Informed consent was obtained from every participant before commencement of data collection and every participant was also assured confidentiality by ensuring that identification features such as

names are not recorded on the research tools. The research instruments were kept in a lockable safe only accessed by the researcher and supervisor.

3.17 Plan for dissemination

The study findings were presented to International Health Sciences University Faculty of Nursing, as partial fulfillment for the award of the degree of Science in Nursing.

And later the results from this study were disseminated to all the stakeholders including administration including authority of and Lubaga division.

CHAPTER FOUR

RESULTS

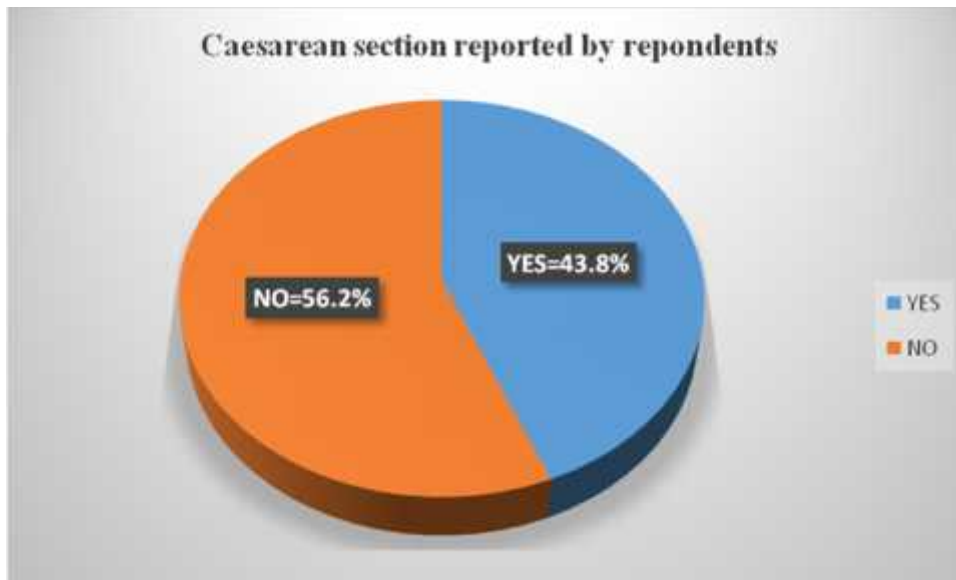
4.0 Introduction

A total of 80 Eritreans living in Lubaga division, Kampala both men and women 18-50 years of age, and already have child/children were interviewed during the period of data collection. During the data collection 95 Eritreans were approached out of this 5 dropped out, 8 did not complete the inclusion criteria and 2 were not willing to participate in the study they said it is the doctor's and nurse's job not theirs to know and figure out. So the researcher continued with the 80 correctly and completely filled questionnaires because it met the sample size. The results of the study are presented according to the study objectives. Results from uni-variate analysis are presented in text and tables. For most findings tables have been used in the presentation of the gathered information.

4.1 Proportion of those who had CS or their wives among the respondents

Regarding the number of women who had CS in their last delivery as reported by the women or the husband interviewed during the data collect period, 35 (43.8%) had had CS in their last delivery as presented in figure 1.

Figure 1: Showing proportion of CS



4.2 Demographic characteristic of the respondents

The majority respondents were in the age group of 21-29 years 43.8% (35/80). Majority of them were females with 56.2% (45/80). The dominant religion was Orthodox at 52.5% (42/80). More than three quarter 77.2% (62/80) of respondents were married, half of the respondents 50% (40/80) were businessmen/women by professions/occupation and most of the respondents 58.8% (47/80) had attained secondary level of education.

Table 1: Showing the demographic characteristic of the respondents

Variables	Frequency(n)	Percentage (%)
Age		
18-20	5	6.2
21-29	35	43.8

30-39	26	32.5
40-50	14	17.5
Gender		
Female	45	56.2
Male	35	43.8
Religion		
Orthodox	42	52.5
Catholic	14	17.5
Moslem	7	8.8
Pentecostal	7	8.8
Born again	10	12.5
Marital status		
Married	62	77.5
Divorced/separated	11	13.8
Widowed	7	8.8
Profession		
Housewife	20	25.0
Business	40	50.0
Student	13	16.2
Accountants	6	7.5
Others	1	1.2
Education level		
Primary	8	10.0
Secondary	47	58.8
Tertiary	20	25.0
Other	5	6.2

4.3 Knowledge factors of the respondents

4.3.1 Awareness about CS

According to the inclusion criteria all the respondents were people who have had had children in their lives. Majority of the respondents 95% (76/80) have heard about CS, from their neighbors and neighborhoods being the main source of information 40.8% (31/76).

Table 2: Showing respondents awareness about CS

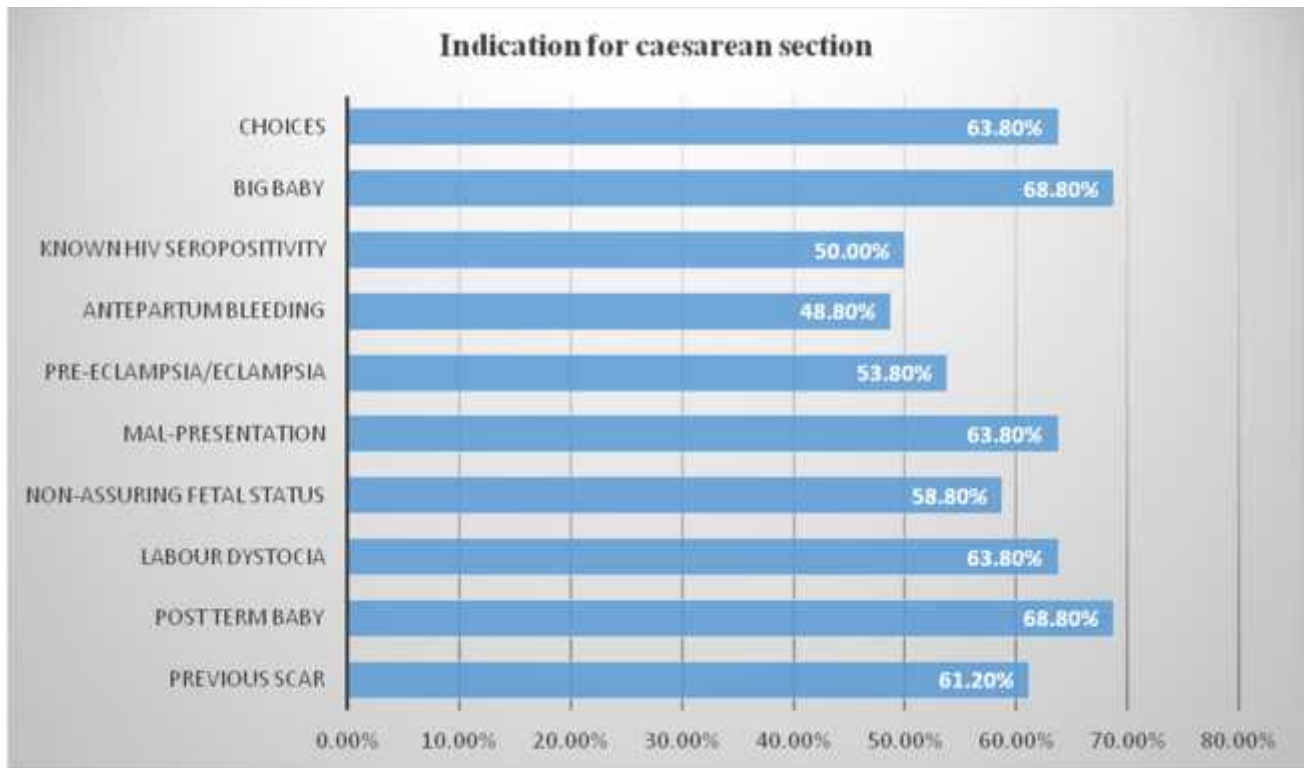
Variables	Frequency(n)	Percentage (%)
Heard about CS		
Yes	76	95.0
No	4	5.0
From where if yes (N=76)		
health workers	21	27.6
neighbor	31	40.8
friend	10	13.2
relatives	12	15.8
others	2	2.6

4.3.2 Indication for CS

On the knowledge of the respondents on some of the indication for CS, 68.8% (55/80) of the respondents mentioned baby size (big baby) and post term baby as the indicators for CS, 63.8% (51/80) of the respondents mentioned labour dystocia, mal-presentation and people's choices

(when one choose to) as indication for CS, 61.2% (49/80) mentioned previous uterine scar/CS, 58.8% (47/80) said non-reassuring fetal status, 53.8% (43/80) mentioned pre-eclampsia/eclampsia, half of the respondents 50% (40/80) said known HIV sero-positivity and finally 48.8% (39/80) mentioned ante-partum bleeding as the indicator for CS.

Figure 2: Showing indication for CS



4.3.3 Knowledge regarding CS

Regarding CS, most of the respondents 65% (52/80) said CS is a major surgery and blood transfusion before and after the procedure is required, 63.8% (51/80) said CS is done under anesthesia, 45% (36/80) of the respondents said CS may lead to admission in intensive care unit, while 42.5% (34/80) of the respondents said there is severe headache in CS. There could be nerve damage was mentioned by 42.2% (33/80) of the respondents, CS cause injury to the

bladder and the uterus 38.8% (31/80), the need for further surgery in the future date was mentioned by 37.5% (30/80) and 22.5% (18/80) of the respondent said an emergency operation to remove the uterus can happen in CS.

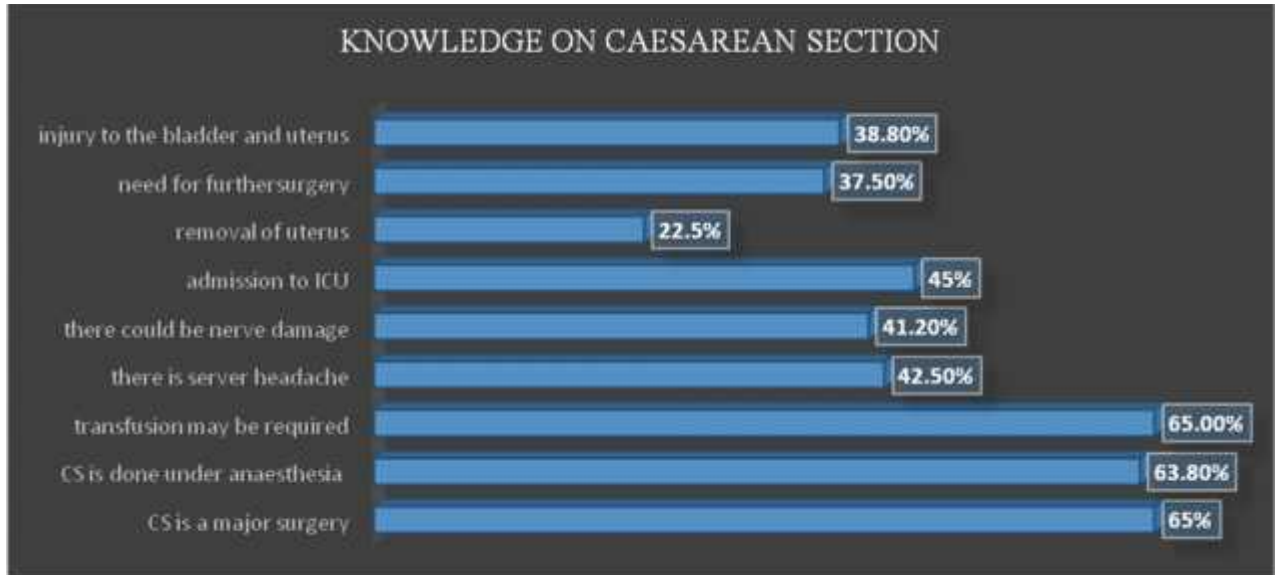
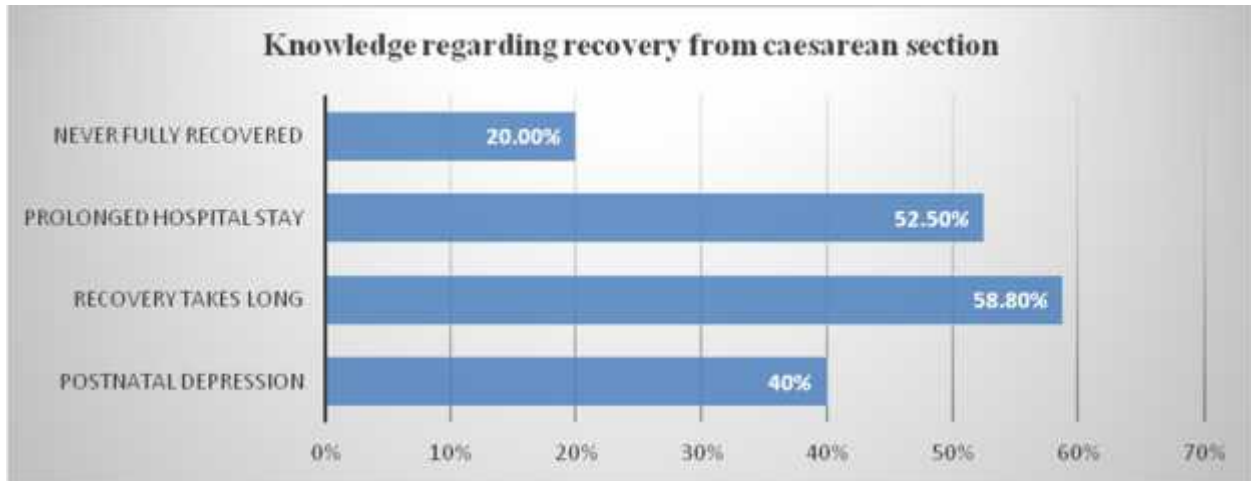


Figure 3: Showing respondents' Knowledge regarding CS

4.3.4 Knowledge regarding recovery from CS

Majority of the respondents regarding recovery 58.8% (42/80) said recovery from CS takes longer compared to spontaneous vaginal bleeding, while 52.5% (42) said CS prolongs hospital stay of the mother, with 50% (40/80) said CS mothers experience postnatal depression due to difficulty in breastfeeding, and 20% (16/80) of the respondents said that mother who went through CS will never fully recover

Figure 4: Showing Knowledge of recovery from CS



4.4 Attitude of the respondents towards cesarean section

Most respondents 75% (60/80) strongly disagreed that CS been the preferred method of delivery and 75% (60/80) of the respondents agreed that they are willing to undergo CS if it is indicated, and 3 of the respondents disagree and 2 strongly disagree to undergo CS even if it is indicated. Other results; 22.5% (18/80) of respondents agreed not to undergo (unwilling) CS even if it is indicated, that fear of dying is a reason for not going under CS 27.5% (22/80), that fear of being mocked is not a reason for not going under CS was mentioned by 41.2% (33/80) while the 11.2% (9/80) agree and 1.2% (1/80) strongly agree that being mocked is one of the reasons that people do not want to go under CS, that a woman is viewed as weak if delivered by CS 13.8% (11/80) but 35% (28/80) disagree with this point. Some respondents agreed that planned CS maybe is a preference method of delivery for some people 38.8% (31/80), willing to undergo a repeated CS was mentioned by 38.8% (31/80), that its God's wish that some women deliver by CS 32.5% (26/80), it is desirous for client education on CS at ANC was 62.5% (50/80), that health workers do CS for

money 61 (76.3/80) and that people go for CS even when the culture doesn't allow 56.2% (45/80) and finally most respondents strongly agreed that CS delivery must first be discussed with your husband 81.3% (65/80).

Table 3: showing attitude of the respondents towards CS

Variables	Frequency (n)	Percentage (%)
CS is the preferred method of delivery		
Strongly disagree	60	75.0
Disagree	10	12.5
Neutral	6	7.5
Agree	3	3.8
Strongly agree	1	1.2
Planned CS is a preferred method of delivery		
Strongly disagree	19	23.8
Disagree	17	21.2
Neutral	6	7.5
Agree	31	38.8
Strongly agree	7	8.8
Willing to undergo CS if indicated		
Strongly disagree	2	2.5
Disagree	3	3.8
Neutral	1	1.2
Agree	60	75.0
Strongly agree	14	17.5
Unwilling to undergo CS even if indicated		
Strongly disagree	17	21.2
Disagree	27	33.8
Neutral	15	18.8
Agree	18	22.5
Strongly agree	3	3.8
Willing to undergo a repeated CS		
Strongly disagree	8	10.0
Disagree	23	28.8
Neutral	10	12.5
Agree	31	38.8
Strongly agree	8	10.0
Fear of dying is a reason for not going under CS		
Strongly disagree	18	22.5
Disagree	25	31.2
Neutral	12	15.0
Agree	22	27.5
Strongly agree	3	3.8

Fear of being mocked is a reason for not going under CS		
Strongly disagree	31	38.8
Disagree	33	41.2
Neutral	6	7.5
Agree	9	11.2
Strongly agree	1	1.2
View a woman as weak if delivered by CS		
Strongly disagree	21	26.2
Disagree	28	35.0
Neutral	7	8.8
Agree	11	13.8
Strongly agree	13	16.2
CS delivery must first be discussed with your husband		
Strongly disagree	1	1.2
Disagree	2	2.5
Agree	12	20.0
Strongly agree	65	81.3
It's God's wish that some women deliver by CS		
Strongly disagree	19	23.8
Disagree	19	23.8
Neutral	7	8.8
Agree	26	32.5
Strongly agree	9	11.2
Desirous of client education on CS at ANC		
Strongly disagree	2	2.5
Disagree	8	10.0
Neutral	6	7.5
Agree	50	62.5
Strongly agree	14	17.5
People go for CS even when the culture doesn't allow		
Strongly disagree	9	11.2
Disagree	7	8.8
Neutral	3	3.8
Agree	45	56.2
Strongly agree	16	20.0
Health workers do CS for money		
Strongly disagree	2	2.5
Disagree	1	1.2
Agree	16	20.0
Strongly agree	61	76.3

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the research findings in relation to the problem statement, literature review of studies conducted elsewhere with and in line with the specific study objectives. It also explains the obtained results from the study.

5.1 Proportion of CS among Eritrean women

Generally, the proportion of Eritrean women who had delivered by CS was high. This could probably be due to that fact that most of the Eritrean women in Lubaga division think the health workers tell them that they should do it to save their lives and the lives of their babies, and the doctors and midwives tell them it is indicated even though they don't believe in it they do it just. This is similar to a recent study in CS and the Caribbean reported that 29.2% of the mothers deliver by CS (Maimoona and colleagues, 2014). This result is not line to a study in the Ethiopia where only 1% of the mothers had CS. The difference in the finding implies that the study settings were difference, this study was carried in urban settings while the Ethiopian study was done in rural setting.

5.2 Knowledge of the respondents on CS

At least more than three quarters of the respondents had heard about CS. This is similar to Aliyu et al, (2013) which reported that 93.8% of the respondents had heard about CS and they were aware about CS. Similarly, Adageba et al; 2006 reported that 96% of the respondents had already heard about CS. Another study finding was similar to this our study, Michael et al, 2003, stated

that the participant women or respondents reported that they have heard about CS from different sources. This implies that CS is talked about during ANC visit where the mothers are always talked to about CS. In this study 40.8% first heard about CS from their neighbors and 27.6% heard about CS from health workers. This could probably be due the fact that they always share information about pregnancy early in their marriage even before pregnancy. This was not in line with a study by Danso et al, 2006 which stated that commonest sources of information for the women were the health workers 34.4% of them heard it from health workers, whereas the 26.5% heard from relatives and the remaining 20.8% heard about CS delivery from the media. Conversely, Micheal et al, (2003) reported that according to their sources of information; 99 (24%) from doctors, 232 (52.2%) from nurses, 39 (9.4%) from friends and 43 (10.4%) of the women did not report their source of information. This difference between these studies implies that common sources of information in the different study settings hence they don't get exactly the same information because of the different sources.

Regarding level of awareness about indication of CS, more than half of the respondents said big babies, postpartum baby, labour dystocia, choice, mal-presentation, and pre-eclampsia/eclampsia are the main indication of CS. This could probably be because couples are health education on CS including its indication during ANC visits. This is similar to study by Ashimi et al, 2013 which reported that 64.9% of the respondents knew that prolonged labour due to big baby. This was also similar to another study by Adageba et al, (2006) which noted that had knowledge about the indications of CS and can actually state some but the given once where: the cervix unable to open, big baby, baby not lying well and mother too ill. Similarly Lawrence et al, (2007) the respondents stated that stated that Cephalopelvic disproportion, prolapse of the

umbilical cord, prolonged premature rupture of membranes, fetal distress and maternal hypertension and placenta praevia were the common reason for undergoing CS.

Regarding knowledge on CS, the knowledge of the respondents on issues regarding Cs was moderate as more than half of the respondents said CS is a major surgery, 65%, blood transfusion maybe required before or after CS, 65%, and that CS is done under anesthesia, 63.8%. This was similar to a study by Ashimi et al, (2013) which reported that 86.4% of the respondents were aware that transfusion of blood during or after the procedure may be required. This could be because people always relate surgical process with blood transfusion and they are aware about the need for blood in CS.

Regarding knowledge on recovery, knowledge of the respondents was good as more than half of the respondents said that recovery due to CS takes longer compared to spontaneous vaginal delivery, 58.8% and that CS prolongs hospital stay, 52.5%. This could probably be because mothers who undergo CS. This was in line with a study by Amole et al, (2013) which noted that the respondents had very good knowledge about the recovery or hospital stay after the procedure, which is normally only a week or less.

5.3 Attitude of the respondents towards CS

Almost eight in every ten of the respondents strongly disagreed that CS was the preferred method of delivery; this could probably due the fact that CS is not the natural form of delivery and spontaneous vaginal delivery which is the natural form of delivery is the most preferred form of delivery for a normal mother. This was in line with study by Kathrin et al, (2009) showed that most men and women respondents' preferred vaginal delivery, with only 9 percent had preference for CS delivery. This could be because preference for CS is linked to fear of

childbirth and driven by low confidence in vaginal birth among different population. Foremost reason for both women's and men's preference for vaginal delivery highlighted that vaginal is "Normal" and "natural" was what was illustrated by comments such as "It is natural and I would like me and my baby to experience it" and "I believe pregnancy is a natural process and that deviating from nature when it is not necessary complicates it further." Significant to the theme of "natural" was a view of vaginal birth as safer and healthier by both men and women, with fewer risks and complications than a CS, for example, "My body was built for birthing, and I believe I should celebrate its capabilities, not subject it to unnecessary harm." Themes for men and women overlapped in vaginal preference, with a noted desire to avoid surgery.

At-least one quarter of the respondents agreed that planned CS is a preference methods for delivery. This could probably be because most mothers would take spontaneous vaginal delivery as the first option but in circumstances where it is not possible or putting the mothers or baby's lives in danger then CS become the preferred methods

Three quarter of the respondents agreed that they were willing to take CS if indicated. This could be probably being because CS is always to save the mother or the baby who might be at danger during to the pregnancy. This was in line with study by Ashimi et al, (2013) which reported that (99%) were willing to have the procedure if indicated. This means that when the mothers have a well explained needs for the procedures they will always undergo the procedure to save her life or the life of her baby. When the women were asked why they accepted the operation, the reasons given by the women were as follows: 'to save my life and that of the baby'; 'I agreed because I attempted delivery before with other hospitals, but with the same problem'; 'I accepted because I felt they were right'; 'I accepted because my scan revealed fetal distress and I wanted to save the life of my baby' and 'I accepted because I wanted to save my life first, and felt (the

problem) was going to kill the baby'. Therefore, the major reason for accepting the CS was to save their lives and that of their babies, in addition they come to have confidence or self believe in the results from the clinical investigation like the Scan conducted by the health providers and this helped to believe and go under CS. However a third of the respondents disagreed to take the procedure even if it is indicated; this could probably be because they be well informed about the important of the procedure when it is indicated and the possible consequences when it is not performed at the right time. This was in line with study by Ashimi et al, (2013) which noted that about half of the respondents were not ready to undergo for fear of dying or pain. Similarly, Kalu, 2011 also reported that the 12.8% of the respondents viewed it as bad and will go under unwillingly if the doctor said so and only 3 (1.1%) viewed CS as very bad and will go through it under any circumstances. This implies that the mothers have fear of cutting and avoidance of scarring may be related to personal and social concerns about the body, body image, and integrity, which surgery disrupts.

More than a third of the respondent agreed that they are willing to undergo repeated CS. This is because the respondents were well informed about the possible numbers of CS one can undergo depending of the mother heath status and the body general condition. This was not in line with study by Ashimi et al, (2013) which revealed that more than three quarter, 82% of the respondents agreed that they would also have a repeat CS. This implies that there was difference in knowledge and the setting of the two studies, as CS is higher in urban setting compared to rural settings.

In this study, only three in every ten of the respondents disagreed that Fear of dying is a reason for not going under CS. This is due to the reason that mothers are informed about the safety of the procedure provided it is performed by profession health practitioners in a well setting facility.

This was not in line with Kalu et al, 2011 where half of the respondents were not ready to undergo because of fear of dying. This different in these studies implies that there is misconception about CS by the study participants due to differences in knowledge about CS.

About four in ten of the respondents agreed that fear of being mocked is a reason for not going under CS. This could probably be because women who delivered by CS are viewed as weak and have failed the natural test of reproduction where a woman is supposed to experience pain and have a natural birth as set by God. And more than a third of the respondents disagreed the View that a woman is weak if delivered by CS. This was in line with study by *Abakaliki et al, 2006* which stated that woman who undergo CS delivery are unfaithful and weak woman. According to Akhtar et al, 2009, delivery by CS is seen as the failure of the women's obstetric responsibility and some said that it is for cursed women. This implies that there is bad cultural beliefs on the women in some community.

In this study, eight in ten of the respondents strongly agreed that CS delivery must first be discussed with your husband. This could be probably because in most African settings the husband is the main decision maker as he is the main source of finance for such procedure. This was in line with study by the Michael et al, 2007 which indicated that the respondents said they would not accept CS because of husband disapproval, many women were worried about their husbands' reaction for going under the operation and some women were showing some regret for having CS. Another study by Amole et al, 2013 stated that they respondents said they would discuss it with their husbands first before the make a final decision.

Almost one third of the respondents agreed that it's God wish that some women deliver by CS. This is because some people that delivery is a natural process so in case some women could not go through normal process then it's could wishes. This was not in line with another study by

Lawrence, 2007 which stated that normal delivery is good because it was ordained by God and anything else from that is God will.

In this study six in ten of the respondents agreed that there is need of client education on CS at ANC. This could probably be because ANC is the best point of getting information regarding maternal child health including CS information to the couple of the mother. This was in line with study by Adageba et al. (2006) which stated that almost all the pregnant women at ANC clinic have heard about CS. This implies that there is high need for the health workers to talk about CS at ANC for the mothers and their partners to get the right information.

Half of the respondents agreed that people go for CS even when the culture doesn't allow. This could probably be because some of the cultural belief and norms are not favorable to the health of the mothers and especially those that doesn't allow the mother to undergo CS putting the mothers and her baby at risk. This was not in line with study by Lawrence O., 2007 which stated that mothers would not go for CS because of fear that CS not being part of culture/custom. Aziken et al 2008 stated that culture and beliefs can also significantly influence the attitude toward CS and culturally biased misconceptions about CS were the main reason for a number of patients refusing this procedure regardless of its necessity.

More than three quarter strongly agreed that Health workers do CS for money. This be probably be because some of the mothers had no previous scar and they believed that could pushed but they are forced into the procedure and the fact that most of the mothers go to private facility. This was in line with s study by Danso et al, 2008 which stated that some mothers had more than three children were recommended CS although they had no complication, and had never had CS before.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter gives a brief summary and recommendations of the study.

6.1 Conclusion

Generally, the proportion of Eritrean women living in Lubaga division who were reported that had caesarean section in their last delivery was at 43.8%.

The level of knowledge about caesarean section was very good as most of the respondents had heard about caesarean section and most of them got the information from the neighbors and the health workers.

The study also found that the level of awareness of indication of caesarean section was good as most of the respondents mentioned previous scar, big baby, postpartum baby, mal-presentation, non-assuring fetal condition, labour dystocia and pre-eclampsia//eclampsia as the main indication for caesarean section.

The level knowledge about caesarean section was good as most of the respondents mentioned that caesarean section is a major surgery done under anesthesia and blood transfusion might be required.

The study also found that the level of knowledge on recovery from caesarean section was good as most respondents stated that recovery caesarean section takes longer compared to spontaneous vaginal delivery and hospital stay is prolonged in CS.

The study also revealed that cultural and religious beliefs of the woman had great influence on the attitude of the woman regarding undergoing caesarean section.

6.2 Recommendation

The following recommendations were derived from the study;

6.2.1 Community leaders

Increased level of the sensitization throughout the country in different languages to enhance knowledge on CS and related topics even by the community to their masses.

The community leaders should also sensitize their community on the poor cultural regarding CS as some community and cultural discourages CS because they believe it is for weak women.

6.2.2 Health workers

The health workers should include a complete information on CS this will allow couples to make informed decision about the health of the mother during pregnancy regarding delivery during the ANC and pregnancy.

The health workers should first encourage their pregnancy women to have a normal delivery as it is the natural form of delivery.

The health workers should do CS at appropriate cost as it is the main way to save mother and baby lives in case the natural form of the delivery is not possible, this is because some health workers over charged money for the procedure making CS to be avoided by the women even if it is indicated.

The health workers should also maintain the ethics by only recommended CS when it is indicated.

6.2.3 Policy makers

The researcher recommends that the government and other stakeholders should put more strict rules and regulations on Concerted actions need to be taken to offer timely CS to women in need and to advocate for a rationale use of CS in the country and unnecessary use of this procedure when it is not required.

There is need to generate awareness and stimulate action regarding caesarean sections by the government and other stakeholders. The ministry of health and other laws bodies should properly implement laws concerning unnecessary CS among the foreigners such as the Eritrean community.

The researcher also recommends that more research still have to be done on the knowledge and attitude of the community on caesarean section especially on cultural effect on uptake of caesarean section.

There are opportunities for possible future research in the future to include other divisions and a longitudinal study can also be done for farther research, lastly the research can be done to see if there is any difference in the attitude and improvement in the knowledge of the community.

REFERENCES

- U.S. National Library of Medicine, *Cesarean Section - A Brief History*, (2013). 8600 Rockville Pike, Bethesda, MD 20894.
- Ashimi, A., Amole, T. and Aliyu, L., (2013). *Knowledge and attitude of pregnant women to caesarean section in a semi-urban community in Northwest Nigeria*. 3(2): 46–61.
- Adageba, R.K., Danso, K.A., Adusu-donkor, A. and Ankobea-Kokroe, F., (2008). *Awareness and perception of and attitudes towards caesarean delivery among antenatal: Ghana Medical Journal* Volume 42, Number 4.
- Aziken, M., Omo-Aghoja, L. and Okonofua, F., (2007). *Perceptions and attitudes of pregnant women towards caesarean section in urban Nigeria*. *Acta Obstetrica gynecologica*. 86:42-47.
- Sunday-Adeoye, I. and Kalu, C., (2011). *Pregnant Nigerian women's View of Cesarean Section*. *Nigerian Journal of Clinical Practice*, Jul-Sep 2011 Issues3 Vol 14.
- Mungrue K., Nixon C., David Y., Dookwah D, Durga S., Greene K., Mohammed H., (2010). *Trinidadian women's knowledge, perceptions, and preferences regarding cesarean section, How do they make choices?* *International Journal of Women's Health* 11/2010; 2:387-91. DOI:10.2147/IJWH.S12857.
- Maimoona, H., Asthma, Y., Nazia, B., Muhammad, I. P., Nishat, A. and Bushra, G., (2014). *Prevalence and Indications of Caesarean Section in a Teaching Hospital In Pakistan* *JIMSA* January-March 2014 Vol. 27 No. 1.

Kathrin Stoll, Nichole Nichole Fairbrother, Elaine Carty, Nane Jordan Carole Miceli, Yarra Vostrcil and Laura Willihnganz, (2009). "*It's All the Range These Days: University Students' Attitudes Toward Vaginal and Cesarean Birth*". BIRTH 36:2 June 2009.

Fatemeh, G., Azadeh, A. S., Eznollah, A., Farideh, S., Mina M., Shahrzad, Z., Farah, F. and Fakhr-al-molouk, Y., (2012). *Women's knowledge and attitude towards mode of delivery and frequency of cesarean section on mother's request in six public and private hospitals in Tehran, Iran*.

Maithri, A., Ryan, B., Jamie, F., Olivera, V., Kelley, S. and Anita, R., (2011). *Somali immigrant women's perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA*, 2011

Arulkumaran, S., (2007) *Obstetric proceeding in Dewhurst's textbook of Obstetrics and Gynecology*. In Keith D (ed). (7th edn) United States: Edmonds Blackwell publishing 547-51.

Nusrat, N., Nisar, A. S. and Ahson, M., (2009). *Knowledge, Attitude and Preferences of Pregnant Women towards Modes of Delivery*, JLUMHS Vol: 08 No. 03.

Tadesse E., Adane, M., Abiyou, M., (1996). *Caesarean section deliveries at TikurAnbessa Teaching Hospital, Ethiopia*. *East Afr Med J* 73: 619-622.

Ngozi, O., Oladosu, A., Inran, O. and Babatunde, O. A., (2012). *maternal demand for cesarean section: perception and willingness to request by Nigerian antenatal clients*, *Int J Womens Health*. 4: 141–148.

Qudsia, Q., Zubaida, A., Kamran, K. and Amer H. K., (2013). *Pregnant Women View Regarding Cesarean Section in Northwest Pakistan*, 2013, 1:1.

Kathrin, S., Nichole, F., Elaine, C., Nane, J. C., Miceli, Y. V. and Laura, W., (2009). *It's All the Range These Days: University Students' Attitudes toward Vaginal and Cesarean Birth*. BIRTH 36:2.

Bereket, S., & Assefash, Z., (2007). *Caesarian section rates in private and public hospitals in Eritrea in 2007*. Orotta National Referral Maternity Hospital, Asmara, Eritrea.

World Health Organization and Unicef, (2010). *Count-down to 2015 decade report (2000-2010): Taking stock of maternal, newborn and child survival*.

Lumbiganon, P., Laopaiboon, M., Gulmezoglu, A.M., Souza, J.P., Taneepanichskul, S., Ruyan, P., Attygalle, D.E., Shrestha, N., Mori, R., Nguyen, D.H., (2010). *Method of delivery and pregnancy outcomes in Asia: The WHO global survey on maternal and perinatal health 2007-2008*. *Lancet*, 375, 490-499.

Shah, A., Fawole, B., M'Imunya, J.M., Amokrane, F., Nafiou, I., Wolomby, J.J., Mugerwa, K., Neves, I., Nguti, R., Kublickas, M., (2009). *Cesarean delivery outcomes from the WHO global survey on maternal and perinatal health in Africa*. *International Journal of Gynaecology & Obstetrics*, 107, 191-197.

Wylie, B.J. and Mirza, F.G., (2008). *Cesarean delivery in the developing world*. *Clinics in Perinatology*, 35, 571- 582.

Dumont, A., de Bernis, L., Bouvier-Colle, M.H. and Berrart, G., (2001). *Caesarean section rate for maternal indication in sub-Saharan Africa: A systematic review*. *Lancet*, 358, 1328-1333.

Siri, V., Camilla S., Anders S., Per M., Babill S.P., (2000). *Cesarean section among immigrants in Norway*.

Ana P. Betrán, Mario Merialdi, Jeremy A. Lauer, Wang Bing-shun, Jane Thomas, Paul Van Look, Marsden Wagner, (2007). *Rates of caesarean section: analysis of global, regional and*

national estimates. Paediatric and Perinatal Epidemiology, vol 21, pp 98 – 113. 1211 Geneva 27, Switzerland.

NATASHA SPENCER *Cesarean Section Rates and Indications at MRRH*

Medscape, Cesarean Section. Available at: <http://emedicine.medscape.com/article/263424-overview> accessed on Oct 2015.

CONSENT FORM

My name is **YORSALIEM GEBREGRIZABIHER TEFAY** a BSN finalist student at International Health Sciences University working on my dissertation.

Research Topic: Knowledge and attitude towards CS delivery among Eritrean community in Lubaga division, Kampala

The purpose of the study: Is to determine knowledge and attitude towards CS among Eritrean community in Lubaga division, Kampala.

Justification: The study is to provide information that can be used to improve on the strategies of involving CS among Eritrean community living in Kampala as well as among Uganda. This would include the urgency of CS when recommended in as an emergency and the indicators for CS knowledge among the community.

Confidentiality: All the information obtained from you will remain confidential and only accessed by the primary investigator. Your participation in this study is completely voluntary free to ask any questions before or after the interview. You are also free to withdraw from the study at any time or decline to participate in the study and you will not be penalized for that.

Benefits of the study: the study will have no direct benefits but the findings of the study will guide the ministry of health in implementing policies on CS in the country as efforts are geared towards the reduction of maternal mortality, especially in high-risk populations, as those that require CS as a mean of delivery.

Risks: There are no risks anticipated to encounter in this study.

Consent

Ihereby confirm that I understand the contents and nature of the research study and I consent that you interview me. I have been assured of total confidentiality and results of this study will not identify me in any way, and also my refusal to answer some questions will not affect me in anyway.

Respondents signature/thumb print..... Date.....

Researcher's/PI's signature Date.....

If you have any questions or concerns regarding the study contact

- Yorsaliem Gebregziabiher Tesfay, at the school of Nursing, International Health Sciences University at 0779133543.
- IHSU-REC chairperson Dr. Samuel Kbwigu; 0779610100
- UNCST contact person Dr. Julius Ecuru; 0772595233

APPENDIX II: QUESTIONNAIRE

PART I: SOCIAL DEMOGRAPHIC

1. What is your age group?

Below 18-20 years () 21-29 years () 30-39 years () 40-50 ()

2. What is your gender?

Female () Male ()

3. What is your religion?

Orthodox () Catholic () Moslem () Pentecostal () Born again ()

Any other.....

4. What is your marital status?

Single () Married () Divorced/separated () Widowed ()

5. What is your profession?

.....

6. What is your level of education?

Primary () secondary () tertiary () any other.....

PART II: KNOWLEDGE ON CAESAREAN SECTION

1. Do you have a child?

Yes () No ()

2. Have you ever heard of caesarean section deliveries?

Yes () No ()

3. If yes, where did you first hear it from?

.....

4. Have you (women), or your wife (men) went through CS?

Yes () No ()

5. Which of the following are the indication of caesarean section (indicate yes if it is an indication and no if it is not an indication)

Previous uterine scar/caesarean section Yes () No ()

Post term baby Yes () No ()

Labour dystocia Yes () No ()

Non reassuring fetal status Yes () No ()

Mal-presentation Yes () No ()

Pre-eclampsia/eclampsia Yes () No ()

Ante partum bleeding Yes () No ()

Known HIV seropositivity Yes () No ()

Big baby Yes () No ()

As a choose (willingly) Yes () No ()

6. Regarding caesarean section:

Caesarean section is a major surgery Yes () No ()

The surgery is done under anaesthesia Yes () No ()

Transfusion of blood before and after the procedure may be required Yes () No ()

There is severe headache Yes () No ()

There could be nerve damage Yes () No ()

Admission to intensive care Yes () No ()

An emergency operation to remove the uterus Yes () No ()

The need for further surgery at a future date Yes () No ()

Injury to the bladder and the uterus Yes () No ()

7. Regarding recovery

There is postnatal depression due to difficulty in breastfeeding Yes () No ()

Recovery take longer compared to spontaneous vaginal delivery Yes () No ()

Hospital stay is prolonged Yes () No ()

The mother will never be fully recovered Yes () No ()

PART III: ATTITUDE ON CAESAREAN SECTION

SD-Strongly Disagree, D-Disagree, N-Neutral, A-Agree and SA-Strongly Agree

		SD	D	N	A	SA
1	CS is the preferred method of delivery					
2	Planned CS is a preference method of delivery					
3	Willing to undergo CS if indicated					
4	Unwilling to undergo CS even if indicated					
5	Willing to undergo a repeat CS					
6	Fear of dying is a reason for not going under CS					
7	Fear of being mocked is a reason for not going under CS					
8	View a woman as weak if delivered by CS					
9	CS delivery must first be discussed with your husband					

10	It's God's wish that some women deliver by CS					
11	Desirous of client education on CS at ANC					
12	People go for CS even when the culture doesn't allow					
13	Health care workers do it for money					

Thank you for your time

PROPOSED BUDGET

S.N	Particular items	Amount	@ Cost	Gross Cost
1	Ruled papers	1 Ream	17,000	17,000
2	Pens	5 pens	500	2,500
3	Flash Disk	1 piece	40,000	40,000
4	Flash Disk	1 piece	25,000	25,000
5	Pencil	1 pencil	500	500
6	Rubber	1 piece	500	500
7	Internet services	5 months	50,000	50,000
8	Typing and printing of proposal	2 copies	75,000	150,000
9	Binding of the proposal	4 copies	7,000	28,000
10	Photocopying of questionnaires	300 copies	500	150,000
11	Analysis (statistician)			200,000
12	Printing and binding the dissertation	Once	200,000	200,000
13	Transport within the 2 division	14 days	15,000	210,000
14	Breakfast	14 days	6,000	84,000
15	Lunch and supper	14 days	20,000	280,000
16	Research assistants allowances	1 for 14 days	10,000	140,000
17	Miscellaneous		100,000	100,000
	TOTAL			1,677,500

WORK PLAN

Activity	August 2015	April 2016	May 2016	June 2016
Proposal writing and submission				
Data collection and analysis				
Writing of the first draft report				
Report submission				

Office of the Dean, School of Nursing

Kampala, 24th May 2016

Tesfaye's Office.....
Rubaga Division Headquarters.....
P.O. Box 7782, Kampala.....
Kampala, Uganda.....

Dear Sir/Madam,

RE: ASSISTANCE FOR RESEARCH

Greetings from International Health Sciences University.

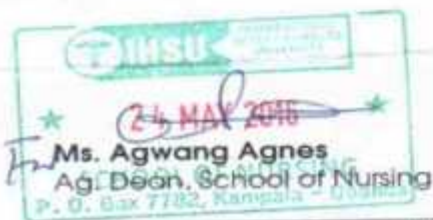
This is to introduce to you **Gebregziabher Yorsalem Tesfay**, Reg. No. 2011-BNS-FT-025 who is a student of our University. As part of the requirements for the award of a Bachelors degree in Nursing of our University, the student is required to carry out research in partial fulfillment of her award.

Her topic of research is: **Knowledge and attitude towards having a cesarean section delivery among Eritrean Community in Kampala, Rubaga Division**

This therefore is to kindly request you to render the student assistance as may be necessary for her research.

I, and indeed the entire University are grateful in advance for all assistance that will be accorded to our student.

Sincerely Yours,


Ms. Agwang Agnes
Ag. Dean, School of Nursing
P. O. Box 7782, Kampala - Uganda

The International Health Sciences University
P.O. Box 7782 Kampala – Uganda
(+256) 0312 307400 email: aagwang@ihsu.ac.ug
web: www.ihsu.ac.ug

Office of the Dean, School of Nursing

Kampala, 24th May 2016

Town Clerk's Office.....
 Rubaga Division Headquarters.....
 P.O. Box 782, Kampala.....
 Kampala - Uganda.....

The student is allowed
 to do her research in
 the Eritrean Community
 living in Rubaga
 Division

27 MAY 2016
 26/5/2016
 Rubaga Division Urban Council

Dear Sir/Madam,

RE: ASSISTANCE FOR RESEARCH

Greetings from International Health Sciences University.

This is to introduce to you **Gebregziabier Yorsallem Tesfay**, Reg. No. **2011-BNS-FT-025** who is a student of our University. As part of the requirements for the award of a Bachelors degree in Nursing of our University, the student is required to carry out research in partial fulfillment of her award.

Her topic of research is: **Knowledge and attitude towards having a cesarean section delivery among Eritrean Community in Kampala, Rubaga Division**

This therefore is to kindly request you to render the student assistance as may be necessary for her research.

I, and indeed the entire University are grateful in advance for all assistance that will be accorded to our student.

Sincerely Yours,

IHSU
 26 MAY 2016
 Ms. Agwang Agnes
 Ag. Dean, School of Nursing
 P. O. Box 7782, Kampala - Uganda