



Exposure and Responses to Information on Caesarean Section (CS) among Pregnant Women in Select Hospitals in Rural Communities of South-West, Nigeria

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ABSTRACT

Background: The negative response towards information on caesarean section among pregnant women in rural communities in Nigeria seems deteriorating, while the maternal/neonatal mortality rate in the country is on a detrimental increase.

Objective: Hence, the aim of this study was to evaluate the exposure of rural pregnant women to information on caesarean section, and their responses to such information, in South-West Nigeria.

Method: The study, which was hinged on Health Belief Model (HBM), adopted a qualitative research methodology, making use of an in-depth interview guide as its research instrument. The instrument was validated by some communication experts and the questions were pretested on some rural pregnant women outside the study area. All the health practitioners within the study area constituted the population, with 15 of them purposively selected as sample for the interview. Data gathered were thematically analysed.

Results: Although the study indicated a gradually improving exposure to CS information among women in South-West Nigeria, yet, responses to such information among the women are still generally negative and aversive.

Conclusion: Exposure to CS information among pregnant women in rural South-West Nigeria is still low, and their responses to such information is also generally negative. Bridging the gap between knowledge and acceptance involves more than information delivery. It requires collaborative engagements with all stakeholders.

Key Recommendation: The study, therefore, recommends a sustainable financial support framework that will engender a comprehensive and absolutely cost-free CS operation for pregnant women, especially those in rural areas in Nigeria.

Unique Contribution: This study has offered empirical evidence that could be useful in addressing the challenges of CS information exposure, and the strategies of communicating such information among pregnant women in rural Nigeria.

Keywords: Caesarean Section; information; process; responses, pregnant women.



INTRODUCTION

Maternal mortality rate in Nigeria, especially in the rural areas, remains a growing concern which should be addressed swiftly by all stakeholders in the country. The low rate of caesarean section uptake in rural Nigeria implies a suboptimal use of the procedure which is worrisome given the high rate of maternal and neonatal mortality in the country. According to Adewuyi et al. (2024), while the ratio of CS in urban areas in Nigeria was 5.2%, it was nearly a quarter of the amount lower in rural areas (1.2%), a report that was corroborated by Ajayi et al. (2023), who argued that women residing in rural areas were less probable to undergo CS compared to those living in urban areas.

In 2018, Nigeria was identified as the nation with the highest maternal mortality rate in sub-Saharan Africa, accounting for around 14% of the global maternal mortality rate (Udobang, 2018). This challenge becomes more worrisome and heightened by the World Health Organisation (WHO) and Integrated Africa Health Observatory's (IAHO) 2023 report, which also ranked Nigeria among the top countries in the African region with the high maternal mortality ratio rate of 1047 per 100,000 live births, a figure that is at a sharp disparity to the 2030 United Nations' targeted projected ratio of 70 per 100,000 live births (WHO & IAHO, 2023).

CS is a birth method that is adopted to deliver a baby when there are medical indications revealing that a pregnant woman will not be able to successfully give birth to her baby naturally through the process of labour. It is not a medical intervention that is alien to pregnant women in Nigeria. But while many pregnant women, especially those living in urban cities are aware and knowledgeable of it, some women who reside in the rural areas have been deprived of quality information about the procedure. Extant literature have identified poor exposure to information on caesarean section as one of the critical predictors of the women's negative responses towards CS, as studies have shown that the level of exposure of women to CS information is shallow and not impressive, and that there is little or poor quality of such information provided by the health practitioners, especially in rural communities where there is insufficient health personnel and facilities (Ukonu et al., 2020; Ngene, Akintoro, Oyeduntan, Idowu, & Balogun, 2022; Ezekiel, Bisandu, & Tsoukan, 2023).

In the South-West region in Nigeria, the prevalence and adoption rate of CS vary geographically as findings from past studies indicate that, while the perception of pregnant women to CS in most urban centres is positive and acceptance rate is high, their counterparts who reside in the rural areas have greater reliance on and faith in alternative medicine, which leads to their continued and increased patronage of traditional birth attendants (TBAs) (Maitanmi et al., 2023; Oladapo, Sotunsa, & Sule-Odu, 2004; Ebuehi & Akintujoye, 2012).

This suggests that pregnant women who are resident in rural areas are more likely to exhibit negative health behaviours towards information on CS than those in metropolis. Therefore, the need for optimal CS communication between healthcare givers and the pregnant women, particularly those in rural areas, to engender maternal/neonatal health outcomes, cannot be over-emphasised.



It is to this end that it has become imperative that studies be conducted to assess the level of exposure to information on caesarean section among rural pregnant women in Nigeria, as well as evaluate their responses to such information, in order to come up with some interventions that can drastically reduce the increasing maternal/neonatal mortality and morbidity rates among mothers and their babies in the country.

RESEARCH QUESTIONS

- i.) What is the level of exposure to information on caesarean section among pregnant women in South-West Nigeria?
- ii.) What is the knowledge level of pregnant women about caesarean section in South-West Nigeria?
- iii.) What is the response of pregnant women in South-West Nigeria towards information on caesarean section?

LITERATURE REVIEW AND CONCEPTUAL CLARIFICATIONS

The Concept of Health Information

The role of health information in promoting sound maternal health of reproductive women cannot be over-emphasised. The critical place or function of communication in any human society is, without doubt, pivotal to the development and growth of such society. Succinctly put, the concept of health communication, therefore, is a strategic and calculated communication effort geared towards disseminating health-related information to targeted audience for the purpose of eliciting desired health response or behaviour, and for the overall goal of promoting healthy living in any given community or society (Aligwe, Nwafor, Ohiri, & Nwabufoe, 2018).

Sudhansubala et al. (2016) argue that health communication is a subfield of communication studies that focuses on the communication patterns and practices utilised in campaigns, health education discourses, awareness programs, and everyday conversations between doctors and their patients--the two main players in the health sector. Also, United States Department of Health and Human Services, (2005), and Centre for Disease Control and Prevention (CDC) (2001), cited in Schiavo (2007), define health communication as the study and application of communication techniques to inform and influence decisions that improve health at the individual and community levels.

According to the World Health Organisation (WHO)'s framework for the quality of maternal and new born healthcare, effective health communication with women and their families helps women feel more involved in their care, avoids needless anxiety, miscommunication and incorrect expectations, and gives women control of their condition which makes for a more positive experience (Kwezi et al., 2021). Sharing their thoughts on the idea of health information, Nicolro-Santa Barbara et al. (2017) contend that for communication to be effective and impactful, there needs to be a strong relationship between the patient and the health provider, as well as collaboration with the women involved in decision-making. They also claim that this process will give the women a sense of empowerment and control which probably shield new



mothers from psychological harm and motivates them to look after themselves. Additionally, they believe that pregnant women who have a better relationship with their healthcare providers in terms of health information sharing, may more likely use information from them that will ultimately enhance health outcomes and be beneficial to both the mother and the unborn child.

Pregnant Women's Knowledge on Caesarean Section in Nigeria

The depth or degree of knowledge of pregnant women on caesarean section may invariably depend on the level of exposure to information on CS among women of reproductive age. The more they are exposed to or have access to channels or outlets through which they can be informed, educated, and learn about the surgical birth method and its procedure, the more these women are more likely to be knowledgeable about the medical intervention, and likely to have positive health behaviour towards it. So, while exposure can be said to refer to openness or accessibility to information on CS, knowledge implies the acquisition, organisation, and application of information, skill and understanding received to make informed decisions on their choice of birth method.

Knowledge about caesarean section among pregnant women in Nigeria vary from one geographical setting in the country to another. While some regions in the southern part show considerable knowledge of the surgical procedure, knowledge of this method is relatively low in the northern part of the country despite high awareness of the medical intervention in the two regions. Rabi, Abubakar, and Mohammad (2019) revealed that while some extant studies conducted in Southern Nigeria indicated that there was a good knowledge of CS, other studies in the Northern part revealed poor knowledge of the procedure.

Similarly, Ashimi, Amole, and Aliu (2013), also beaming searchlight on the knowledge level of pregnant women about CS in Northern Nigeria, revealed that despite a very high percentage of respondents (93.8%) that showed awareness of the birth method, about 40.9% had adequate knowledge of it. This, they attributed to the fact that most of the respondents surveyed were not educated, and were unemployed, hence, they solely depended on their husbands.

Conversely, in a South-South Nigeria, a study by Utuk et al (2018) which indicated a very high level of knowledge of CS, attributed this finding to the fact that both the pregnant women and their husbands had tertiary level of education. However, the study conducted by Faremi, Ibitoye, Olatubi, koledoye, and Ogbeye (2014) in South-West Nigeria, showed that only 17.1% of the women surveyed have good knowledge of caesarean section as a method of birth. Their findings revealed that 69.5% of the respondents were aware that CS is a less painful birth alternative than vaginal deliveries, yet, majority of them still believed that vaginal deliveries may foster mother-child bond.

Responses to Information on CS, and its Implications on Maternal Health in Nigeria

The responses to information on CS in Nigeria vary in degrees from one pregnant woman to the other depending on so many variables such as socio-economic, religious or cultural factors. In contrast to developed nations where women frequently accept CS due to their increased awareness of its role and safety, pregnant women in developing nations, such as many sub-



Saharan African nations, are frequently reluctant to accept the surgical procedure, as multiple reports have shown (Aziken et al., 2007). According to their study, responses of the women to information on CS revealed that only 6.1% were willing to accept CS as a birth method of choice, while some (12.1%) even indicated that if there are health risks of death or morbidity to them or their babies, they would still not accept the surgical method of birth delivery.

This negative response to CS is corroborated among women in South-West Nigeria in a study by Faremi et al. (2014) when they reported that only 6.9% of the respondents indicated interest to accept caesarean section as their birth mode of delivery, as majority of the respondents agreed that vaginal delivery creates more mother-child bond than CS, and as such, 85.7% indicated that they would rather prefer vaginal or spontaneous mode of birth delivery.

Summarising the experiences and responses of women to CS birth method especially among women dwelling in rural areas, findings of Edward, Bolarinwa, Ajibade, and Aregbesola (2023) in their study conducted at a rural health centre in South-West succinctly put this into perspective, as they came to the conclusion that most women would still prefer vaginal delivery to caesarean section birth because they still believe it is a natural delivery and there is a sense of joy associated with it. But the implications of the negative responses or attitude of pregnant women towards CS birth method on maternal health can be far-reaching, especially in developing countries like Nigeria.

As aptly emphasised by Ezeonu et al. (2017), the refusal to accept caesarean section as an alternative childbirth option to vaginal mode of delivery has been linked to poor maternal and perinatal outcomes, which frequently result in mortality or morbidity among women of reproductive age and their babies. This position is consistent with the reports of study conducted by Chigbu and Iloabachie (2007), which investigated the health outcomes of CS refusal among pregnant women in Enugu (South-East), Nigeria. According to their findings, the group that refused elective caesarean sections died at a significantly higher rate than the group that accepted them, and the maternal mortality ratio at one of the healthcare facilities under investigation (University of Nigeria Teaching Hospital, Enugu) was 1406 per 100,000 live births.

In a nutshell, Ivie et al (2024) highlighted the potential dangers resulting from the non-acceptance of CS if medically indicated to include: increased risk of major morbidity or mortality for the mother, adverse psychological sequel, and problems in subsequent pregnancies including uterine scar rupture, as well as greater risk of stillbirth and neonatal morbidity. This position was encapsulated by Edward et al (2023), and Babarinde (2024) when they claim that a pregnant woman's refusal to consent to a caesarean section when vaginal delivery is no longer an option, may endanger her life and the life of her unborn child, possibly leading to one or both of them dying.



THEORETICAL FRAMEWORK

Health Belief Model (HBM)

This study was anchored by Health Belief Model (HBM). This model was developed in the 1950's by a group of behavioural scientists (Hochbaum, Rosenstock, Kegeles, and Leventhal). The fundamental principles of HBM emphasise that people's beliefs impact their health-related behaviours, and that their willingness to conduct desirable or undesirable actions, depends on a number of beliefs or circumstances.

The fundamental tenet of HBM which emphasises on the health beliefs of people as having influence on their health behaviour, is highlighted in this study. The tenet explains contextually how the level of exposure to information on caesarean section among pregnant women in rural South-West Nigeria, and their responses to such information depend largely on the health beliefs held by the women concerning CS, as well as their perceived net benefits of the new health behaviour.

METHOD

The study employed a qualitative research methodology, using an in-depth interview guide as instrument to gather data on exposure and responses to information on caesarean section among pregnant women in selected hospitals in rural communities in South-West Nigeria.

The population of the study was all the health practitioners across the South-West states in Nigeria. From the six states in South-West geo-political zone in the country, three states (Ogun, Oyo, and Osun) were selected using simple random sampling technique. From each of the selected three states, five local government areas were randomly selected, and from each local government area, one health practitioner was purposively selected (those who engage in health talk during antenatal clinic), and this amounts to a sample size of 15 informants for the in-depth interview.

This study provided answers to the three research questions using Nvivo 14 software package to thematically analyse the data gathered from the interview informants in theme, theme and theme. The informants' identity were not disclosed as a respect of their privacy rights, thus the code names of R1, R2, R3, etc., used in the analysis.



DATA PRESENTATION AND FINDINGS

Theme 1: Exposure Level to CS Information

The finding on informants' perceptions revealed a mixed understanding of the adequacy of exposure to CS information among the pregnant women. The interpretations suggest that though exposure is limited, it varies significantly and influenced by factors such as fear, cultural beliefs, and geographical locations.

In view of this, the informants' responses highlight diverse perceptions of exposure adequacy. For instance, R1 perceives a sufficient level of exposure, attributing it to adequate time allocation during health talks, stating: "Yes, I will say they are, they are exposed. The time allotted to CS talk is long enough. Time is not actually our problem here." Similarly, R6 supports this view, noting targeted education for first-time mothers: "Yes, they are exposed enough to CS information. We don't only talk on CS, we talk generally. But we talk more on CS to the primi i.e. those women who are pregnant for the first time..."

In contrast, other informants highlight significant gaps in exposure. R3 points to cultural barriers:

Here, the women are not informed enough. The major challenge we have here is cultural belief. We have the Yorubas, the Eguns, the Aworis. So because of their cultural norms and beliefs, the information about caesarean section is not well grounded here.

R5 echoes this, noting recent efforts and fear as barriers:

I will say people around here are not all that exposed to information on CS. It's just recently we started talking to them about it and most of them are just getting informed about it. Most of them have this feeling of fear of unknown, may be that's why they are not really coming in for that...

Furthermore, R7 indicates limited pre-antenatal exposure, "Most of our pregnant women here are not that exposed to information on CS until they register and begin to come for antenatal clinic session," while R9 attributes resistance to rural settings:

Not really, because they don't want to hear anything about CS, most especially women that are in rural setting. Secondly, the time allotted to sharing CS messages during the general health talk is not long enough because we have a lot of things to explain to them. Breastfeeding is there, nutrition is there, and so on and so forth. So, we just talk about CS briefly.



Theme 2: Knowledge Level about Caesarean Section

Theme 2 explores pregnant women's knowledge level about caesarean section. Knowledge plays a vital role in shaping attitudes, reducing anxiety, and supporting informed decision-making regarding CS. The majority of informants report low initial knowledge levels. R2 estimates, "Before they started antenatal clinic session, they are not that knowledgeable about CS. Let's say about 40%," while R3 rates it lower:

Okay, if I have to rate that on a scale of 100%, maybe I will give them 20%. Whatsoever they learnt from their families, relatives, friends, do not give them accurate information about CS, so coming to the antenatal clinic, we let them know what CS entails...

Furthermore, R5 concurs thus:

I will say the knowledge is not high. If I have to rate it over ten, I will say may be four. Some of them, it is when they come that they have more understanding because some of them do believe in what they hear outside...

R10 states, "Let me say 4%. Their knowledge level is very low." R11 adds:

Let me say it's almost zero because of their perception to CS. Even if you inform them during labour that they cannot deliver the baby naturally and they need to undergo CS, you will start hearing them saying "Eeh, Ori mi ko, Iseda mi ko", meaning, "My God forbids that, my creator rejects that".

Meanwhile R12 notes, "Their knowledge about CS before they started coming for antenatal is very low". R13 supports this, "They don't have much knowledge, their knowledge is usually low about CS before they started the clinic. You know they do believe that our own culture does not support childbirth via CS", and R15 concludes, "It is so low. It is so low because it is not welcoming to them."

Theme 3: Responses to Information on Caesarean Section

Theme 3 explores how pregnant women in Nigeria respond to information on caesarean section. The spectrum of responses which range from outright rejection to gradual acceptance with education, reflect a complex interplay of cultural beliefs, fear, and limited pre-antenatal knowledge. The finding indicates predominantly negative responses, with many viewing CS as a "death sentence" due to misconceptions and traditional preferences for natural birth.



Most informants describe poor and negative responses. R1 rates it, "Very poor, very negative. If I were to rate it over 100%, I will give it 10%," while R2 states:

Their response is very negative. Most of them don't want to accept the method. They don't believe in it. They prefer to birth naturally through vagina despite all the explanations you give to them that their medical conditions will not allow them to do so.

R4 notes, "It is quite poor. The attitude is not encouraging. Although, some of them after long persuasion and thorough monitoring eventually agree to go for CS, but majority of them do not want to hear about it" and R5 adds, "Their response is nothing to write home about. Very poor and negative. They don't want to hear about it at all". R6 elaborates on the health behaviour situation thus:

The attitude of most of them is negative. Their health behaviour is quite poor towards information on CS. Once they are informed that there will be need for them to be operated upon when the time of their childbirth comes, they usually reject it outrightly and will rather prefer to start attending traditional birth homes believing that the medical conditions that necessitated the reason for that CS will be upturned through herbal concoctions...

However, few informants noted gradual improvement with education. R6 notes: "But some of them, after thorough health education and persuasion, sometimes succumb to go for the operation." R13 adds, "Most of the times, they are always against it, so, their attitude towards it is so poor. But, when we give them education on it, some of them show positive response towards it".

Nevertheless, some informants attribute the pregnant women's negative response to financial constraints. For instance, R1 notes: "Yes, I consider it a challenge among the pregnant women. Most of them cannot afford the cost of the operation..." While R2 states, "Yes, it is a serious barrier in a rural area like this because most of the women are poor and may not be able to afford the cost of the operation." R3 concurs, "Yes, for majority of them, this is a huge challenge. Most of them cannot afford the cost of undertaking CS operation." and R4 adds, "Yes, it is a serious barrier because of their poor income status. This is a rural area, and as such, majority of them cannot afford the cost of CS operation." R5 observes, "Yes, to some of them it is a challenge despite the fact that the cost of the operation in public hospitals is much lower than what the private hospitals charge". while R6 elaborates: "Absolutely. The cost of undergoing CS is quite on a high side for women in the rural areas. Despite the health insurance scheme introduced by some South-West State Governments, yet, most of these women cannot afford the cost..."

Furthermore, other interview informants gave another perspective into what could be responsible for the women's negative response to CS information. They identify distance as a barrier. R1 states, "Yes. The distance of the health facilities to the women brings up the issue of



transportation cost," while R2 adds, "Definitely. The distance or location of some of the women to the available primary health centres is far and this may discourage them from accessing or making use of the facilities". Expressing his perception, R3 notes, "Yes, I will say some locations of some of the facilities can pose a challenge or barrier to accessing some of these facilities." and R4 confirms, "Yes, as I earlier said, some of them come from long distance places." R5 elaborates, "Yes, some of the locations of these facilities are far away from the pregnant women," and R6 says, "Yes because some of them do come from long distance to the facility where they registered." R7 adds, "Yes. The location of health facilities is a bit of a distance to where most of our patients reside. This makes most of them to feel discouraged from coming to maximally use the health facilities".

DISCUSSION

The findings of this study provide key insights into pregnant women's exposure to, knowledge of, and responses towards caesarean section information in rural South-West Nigeria. The study highlights how cultural, socio-economic, and fear mediate both the reception and interpretation of CS messages.

Exposure to Caesarean Section Information

The study found variability in exposure levels across locations: areas such as Ipokia and Iwo offered extended health talks on CS, while Ado-Odo and Imeko-Afon reflected weaker exposure due to cultural constraints and limited antenatal preparation. These findings echo Miremberg et al. (2022) and Zahroh et al. (2023), who emphasised the importance of structured antenatal education for reducing anxiety and supporting informed maternal choices.

The finding of this study which highlighted that there is a low level of exposure to CS information, resonates with the outcomes of the study by Olajubu et al. (2018), which underscored a significant relationship ($P < 0.001$) between access to CS information and acceptance of the CS procedure as a birth method. This implies the need for better improvement in the literacy level in the rural region to boost exposure to CS education and information. Similarly, this study's finding further corroborated the results in the work of Chigbu and Iloabachie (2007), which also emphasised that lack of exposure to CS information among pregnant women in Nigeria is one of the major reasons for their refusal to accept CS.

Knowledge of Caesarean Section Information

This study revealed a low knowledge about CS information among pregnant women in rural South-West Nigeria, especially before they started antenatal clinic. This finding is, however, in contrast with the results of the studies by Bukar et al., 2014; Panti et al., 2018; Ashimi et al., 2013; Maitanmi et al., 2023; Ogunlaja et al., 2018; and Edward et al., 2023, which revealed that majority of the women surveyed had good knowledge of the surgical birth method, as well as the finding of Aminu et al. (2024) which also revealed an average level of knowledge about CS among their respondents. The low knowledge about CS highlighted in this study, mirrors Khan et al. (2019) and Dorkenoo and Abor (2021), who highlighted both the impact of misinformation and the need for targeted antenatal educational interventions and CS communication.



This underscores the vital role education plays in influencing the knowledge and attitude of childbearing women towards CS in Nigeria. Also, in line with the Social Cognitive Theory (Bandura, 1986), educated women likely benefit from higher self-efficacy, enabling them to interpret and act upon medical advice more confidently. This suggests that educational attainments play a major role in shaping knowledge about CS.

Responses to CS Information

Responses to CS information, shaped by fear, stigma, and cost concerns, were predominantly negative among women in rural South-West Nigeria. Many interview informants described the reactions or responses of the women towards CS information as if they received “death sentence,” echoing findings from Madu (2023) and Robinson-Bassey & Juliet (2016), who reported that fear of death and surgical risks dominate women’s perceptions of CS. This highlights the cognitive–emotional gap: knowledge does not always translate into acceptance due to cultural and emotional barriers (Shafqat et al., 2015).

The Cultural Theory of Risk (Douglas & Wildavsky, 1982) offers a useful frame: women’s fear-driven resistance reflects collective cultural narratives that position CS as undesirable, unnatural, or spiritually dangerous. Similarly, the Theory of Planned Behaviour (Ajzen, 1991) suggests that even when women know CS can save lives, negative attitudes (fear, stigma), subjective norms (family/community disapproval), and perceived lack of control (financial cost) constrain intention to accept it.

Findings of Ezeonu et al. (2017) are also consistent with the outcomes of this study in terms of general negative response towards CS information, as it indicates that despite a very high number of their respondents have heard CS in the past (82.3%), this did not suggest acceptability of the procedure. This view was shared by Aziken et al (2007) who highlighted in their study that in spite of the good knowledge about CS that the majority of the women they surveyed possessed, yet, only 6.1% of them were willing to accept CS. This submission was also supported by the findings of Adewunmi and Farotimi (2024) which revealed that CS was perceived as a “curse”, and a “failure of womanhood” among the women.

CONCLUSION

Succinctly put, the study’s findings reveal that acceptance of CS information remains hindered by a convergence of fear, cost, cultural beliefs, and infrastructural limitations. A more holistic approach, encompassing culturally sensitive education, financial protection schemes, and improved access, is required to transform information exposure into informed, empowered decision-making. Bridging the gap between knowledge and acceptance involves more than information delivery; it requires collaborative and sustained engagement with all stakeholders in and outside the rural communities in Nigeria in order to improve maternal health outcomes in rural Nigeria. Sequel to the findings of this study, the followings are recommended:

- i.) Based on the general low knowledge level and exposure to CS among pregnant women in rural South-West Nigeria, hospitals managements of various health centres in the rural communities in this region, and Nigeria by extension, should in synergy with government



functionaries, community and religious leaders, strategically design culturally sensitive CS education programmes, and vigorously embark on community outreach and health campaigns on CS in order to further sensitise and educate the women on the CS birth method.

- ii.) Governments at all levels in Nigeria should further incentivise pregnant women, especially those in rural areas, by making CS birth method absolutely free of charge, as most of the women are indigent and lack the financial strength to afford the cost of CS surgical operation even at subsidised rate. This can potentially increase uptake of the birth method among the rural women in Nigeria.
- iii.) Moreover, all the tiers of government should take healthcare delivery closer to the doorsteps of pregnant women in rural communities, by providing more primary healthcare facilities that are easily accessible to the women.

Ethical Clearance

Ethical clearance was sought and obtained from the Ministry of Health of each of the South-West States where the study was conducted.

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Conflict of Interest

There was no conflict of interest.

Author's Contributions

Babatunde Stephen MAKU conceived the concept, designed the study, and as well, collected, analysed and interpreted the data. He was the one that wrote the manuscript. The author read and approved the final manuscript for publication in its current form.

Availability of data and materials

The datasets on which conclusions were made is available in the form of Microsoft Word. It is available on reasonable request.

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