

KNOWLEDGE, ATTITUDE, AND PERCEPTION OF WOMEN REGARDING C-SECTIONS DURING THEIR ANTENATAL PERIOD IN A TERTIARY CARE HOSPITAL OF MULTAN DISTRICT

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ABSTRACT

Background: A C-section is a standard surgical procedure for complications in childbirth to ensure the safety of the mother and the child. There are global C-section rates that are on the rise and in low-risk pregnancies, it can be done without medical need.

Objective: The current cross-sectional study aimed to assess the knowledge, attitudes, and practices (KAP) of women regarding C-sections during their antenatal period at a tertiary care hospital in Multan, Pakistan.

Material and Method: Using a purposive sampling technique, data were collected from (N=250) pregnant women attending antenatal clinics, M=27.09; SD=5.25). A structured questionnaire was used which included maternal knowledge regarding C-sections, attitude towards this type of delivery, and perceptions in terms of risk and benefits.

Results: The study found that prenatal education must address gaps in knowledge that lead to excessive dependency on C-sections. Results emphasize that interventions could help pregnant women make better decisions that will positively impact maternal and fetal outcomes. Future studies should explore how what caregivers say, what culture says, and what the media say affect what women choose and their decision on whether to get a C-section.

KEYWORDS: cesarean section, antenatal care, knowledge, attitudes, perceptions, maternal health, healthcare education.



INTRODUCTION

A C-section is an important operation done on a woman to ensure a safe delivery of her baby can happen. A C-Section is done when the vaginal delivery cannot happen. However, the global rise of C-sections has raised concerns about their overuse, particularly in low-risk pregnancies, for which it may not be an indication. The idea of too often getting a C-section is a problem all over the world. The C-section rate has jumped up dramatically, reaching about 21% across the world in 2019. According to WHO, 5-15% is the recommendation for C-section rates. In Pakistan, the C-section rate stands at 22%, with the urban area rate being far higher than the rural area rate [1]. Researchers have taken notice of the trend of pre-planned and repeat C-sections. This makes many researchers interested in finding out the determinants of choosing C-sections during the antenatal period, especially in Pakistan [2]. A woman's knowledge, attitude, and perception (KAP) regarding the Cesarean section (C-section) are essential to understanding the decision-making process regarding how to give birth. A person's cultural norms, education, socio-economic status, and access to health care are important determinants of KAP. In Pakistan, vaginal delivery is often considered the normal, and C-section delivery is the last option unless necessary.[3] [4]. But in cities and modern lifestyles, women are increasingly seeing C-section deliveries as a safer and more convenient option due to the fear of labor pain and because they can schedule the delivery [5, 6]. Changing beliefs around birth have made it essential for the education of women regarding their delivery. It is essential to make informed choices based on proper knowledge, not on anything else, like tradition, family, or the doctor's choice.

The period before delivery, which is the antenatal period, is a crucial time during which one can educate women about C-section and delivery in general. However, this opportunity gets missed out on more often than not. Many pregnant women in Pakistan are not aware of the risks, benefits, and indications of C-sections [3, 5]. Many women still believe the myth that C-sections are safer or lower risk, or the opposite myth, that they're dangerous and should be avoided at all costs [7]. Due to deficient prenatal counseling and unavailability of a trained provider, particularly in rural areas, women tend to depend upon these versions, which get filtered through traditional and familial sources, having less veracity. The limited knowledge available to pregnant women



significantly impacts their decision-making process, potentially leading to either unnecessary C-sections or the avoidance of medically necessary ones.

Rationale & Research Gap

C-section rates are increasing globally. Concerns have arisen that they may be overused, particularly in low-risk pregnancies. Mothers and infants alike face medical risks from unnecessary C-section births [8]. The C-section rates in Pakistan are on the rise, with the urban sector recording higher rates than the rural sector [1]. Although the procedure has medical benefits, knowledge of it is still lacking in many pregnant women, leading to several misconceptions that affect decision-making [7]. Research shows that the knowledge, attitude, and perception (KAP) of women affect their mode of delivery, but there is limited research on the KAP of women regarding C-sections in Pakistan [3]. Educating pregnant women could limit unnecessary C-sections and ensure good maternal and neonatal outcomes. Thus, antenatal education is essential. The present study aims to assess the KAP of women about section C in a tertiary care hospital in Multan, Pakistan, and how their socio-cultural and educational factors influence their choices.

Objectives

- To evaluate women's knowledge, attitude, and perception regarding C-Section during the antenatal period in the tertiary care hospital of Multan.
- To see how education, money, and past delivery experiences affect women's views on C-sections.

Hypotheses

- Women's education and knowledge about C-sections are significantly related during the antenatal period.
- Women who have had a previous childbirth will have a more positive attitude toward C-sections as compared to those without.
- A woman's attitude toward the necessity of a C-section and her perception of this procedure is affected by her socioeconomic status. The higher the socio-economic status, the more likely to opt for elective C-section.

Method

Sample

For this research, the cross-sectional research design was used, and sample selection was done by the purposive sampling method. Researchers gathered data from 250



pregnant women who were visiting antenatal clinics at a tertiary care hospital in Multan, Pakistan. Further, the mean age of the participants was 27.09 years ($SD=5.25$). Participants were chosen selectively as per set inclusion criteria. The participants were pregnant women and attending antenatal care. Women aged 18 years or older, able to give informed consent, and able to speak Urdu or English were included. The participants had different educational qualifications, employment statuses, socioeconomic statuses, urban or rural backgrounds, family backgrounds, and marital status. The data were collected through face-to-face interviews inside the antenatal care units of the hospital. Women who were not pregnant at the time, women who did not come to antenatal clinics, women who cannot give consent, and women who had chronic medical or psychiatric problems were excluded from the study. The sample was appropriate for the investigation of the knowledge, attitude, and perception regarding C-sections in the study population.

Measures and Data Collection Procedure

The study obtained formal approval from the institutional review board (IRB) and the research ethics committee of the hospital where the study was conducted. The hospital administration permitted the data collection, with proper authentication for the same. Before implementing the major data collection, permission was obtained from the authors of the scales used in the study. To determine whether the items in the survey are suitably designed, a pilot test was conducted on 30. The feedback from the pilot phase was used to make changes in the questionnaire. The antenatal clinics in Multan's tertiary care hospitals were used for data collection. They asked the pregnant women attending their routine antenatal visits. The Knowledge of C-Sections Scale (KCS), Attitudes toward C-Section Scale (ATCS), Perception of C-Section Necessity Scale (PCNS), and Kessler Psychological Distress Scale (K6) were administered to each participant in a private area of the concerned hospital. Before starting the interview, the aims of the research study were explained to the participants. Further, they were also informed that participation was voluntary and that they could withdraw at any time. All the participants gave their informed consent before the data collection was done.

The questionnaire was administered to them, asking if they would prefer to have it in Urdu or English. Information was gathered using in-person interviews and responses were noted down. Once completed, the information was entered into SPSS (Version 27). The demographic details and scale scores were summarized using descriptive statistics. The test of study hypotheses was done with the help of inferential statistics.

Result

The findings show that the participants' knowledge was mostly low to moderate, with misperceptions like C-section has no risk at all or C-section is responsible for grave complications.

Table 1

Test of Normality

	Kolmogorov-Smirnov		Shapiro-Wilk	
	<i>Statistics</i>	<i>P-value</i>	<i>Statistics</i>	<i>P-value</i>
Knowledge	0.38	0.01	0.68	0.01
Attitude	0.23	0.01	0.85	0.01
Practice	0.28	0.01	0.79	0.01

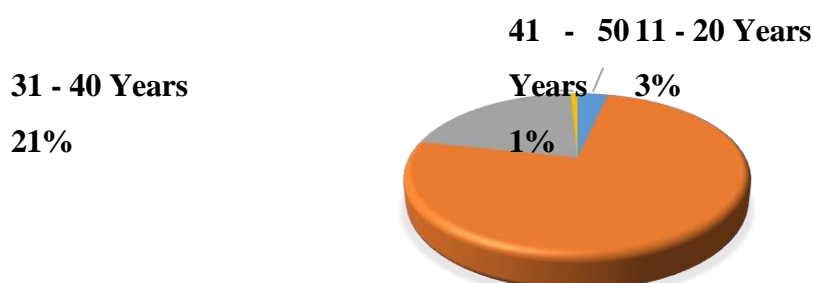
The results of both the Kolmogorov-Smirnov and Shapiro-Wilk tests consistently show that the distributions of Knowledge, Attitude, and Practice scores are non-normal. This finding suggests the need for non-parametric statistical tests to analyze these variables in subsequent analyses. Non-parametric methods are better suited for data that do not meet the assumptions of normality, ensuring more accurate and reliable results.

Table 2

Descriptive Statistics for Age

	<i>N</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Mean ± Standard Deviation</i>
Age	259	17	42	27.09 ± 5.25

The data shows that the sample included females ranging from 17 years to 42 years, with a mean age of 27 years. This age bracket is ideal for studying the reproductive status and childbirth preferences of females.





21 - 30 Years

75%

Figure 1: Pie Chart of Age Distribution

Table 3

Descriptive Statistics for Occupational Status

Occupation	Frequency	Percent
House Wife	201	77.3
Employed	40	15.4
Self-employed	18	6.9

More than three-quarters of the sample are housewives; this gives a gender or role bias in the convenience sample population. A much smaller proportion of women is either working (15.4%) or business owners (6.9%), indicating low engagement in paid work aside from managing homes.

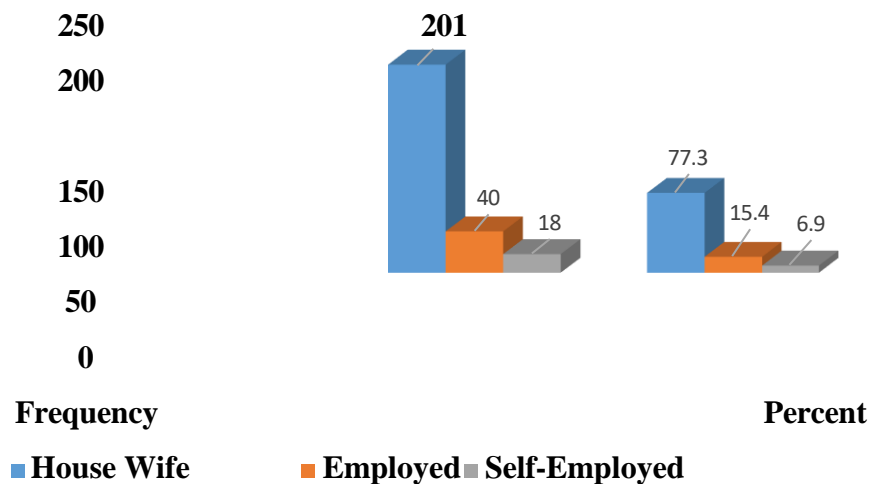


Figure 2: Bar Chart of Occupational Status

Table 4

Descriptive Statistics for Place of Residence

Place of Residence	<i>Frequency</i>	<i>Percent</i>
Urban	177	68.1
Rural	82	31.5

According to the latest census, the lower 2/3rd of the total population belongs to urban areas, which are 68.1%, indicating urban bias or sampling of the urban population. Out of them, slightly over one-third (31.5%) live in rural settings, suggesting that there is an under-representation of participants from rural backgrounds.

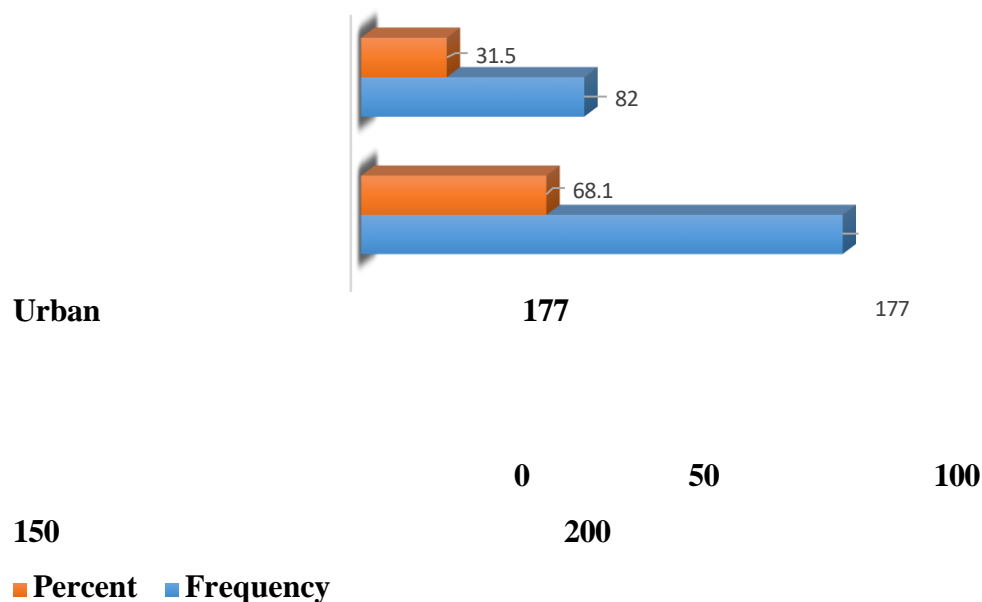


Figure 3: Bar Chart of Place of Residence

Table 5

Descriptive Statistics for Educational Status

Educational Status	Frequency	Percent
No Formal Education	35	13.5
Primary	76	29.2
Secondary	116	44.6
Higher Education	32	12.3

About half the population has completed secondary schooling (44.6%), and only a small proportion has attended higher education (12.3%). About Basic Education, 29.2 percent had attained their education up to the Primary level, while the other 13.5 percent never attended school. This stresses inequity in the distribution of education for the population under review.

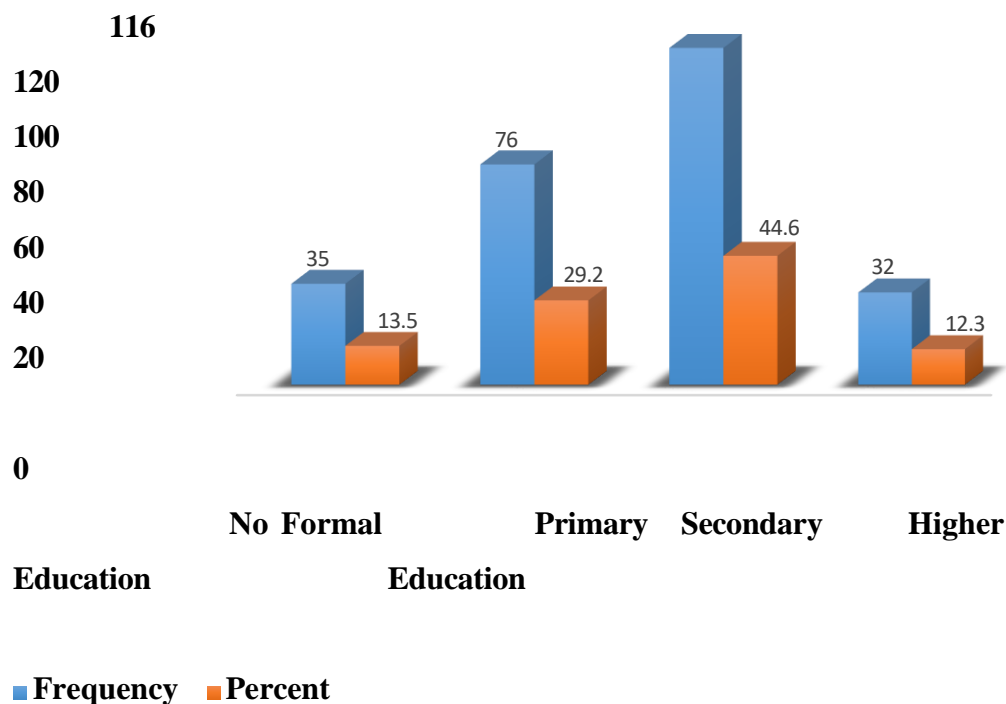


Figure 4: Bar Chart of Educational Status

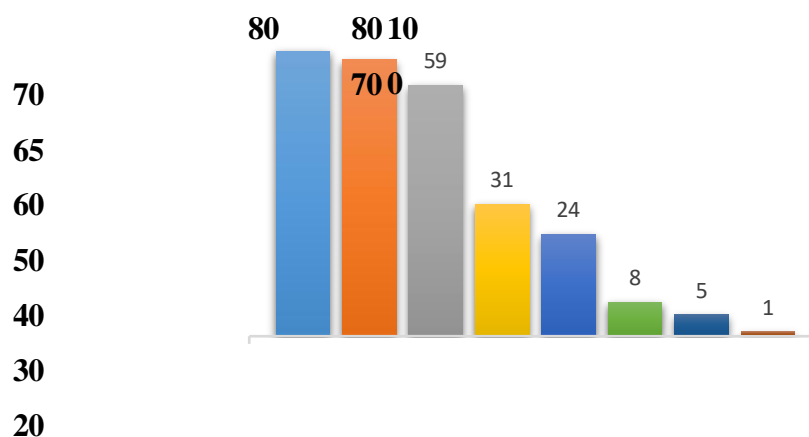


Table 6

Descriptive Statistics for Previous Pregnancies

Previous Pregnancies	Frequency	Percent
0	67	25.5
1	65	25
2	59	22.7
3	31	11.9
4	24	9.2
5	8	3.1
6	5	1.9
7	1	0.4

The data represents the distribution of individuals based on the number of previous pregnancies. The most common group comprises individuals with no previous pregnancies, accounting for 25.5% of the total, followed closely by those with one (25.0%) and two previous pregnancies (22.7%). Together, these three groups make up over 73% of the dataset. Individuals with three and four previous pregnancies represent 11.9% and 9.2%, respectively, indicating a moderate frequency. The least common groups are those with five, six, or seven previous pregnancies, comprising 3.1%, 1.9%, and 0.4% of the total, respectively. This distribution shows a clear trend of decreasing frequency as the number of previous pregnancies increases, with most individuals concentrated in the range of zero to two pregnancies. These patterns could reflect demographic, health, or socioeconomic factors influencing reproductive trends within this population.



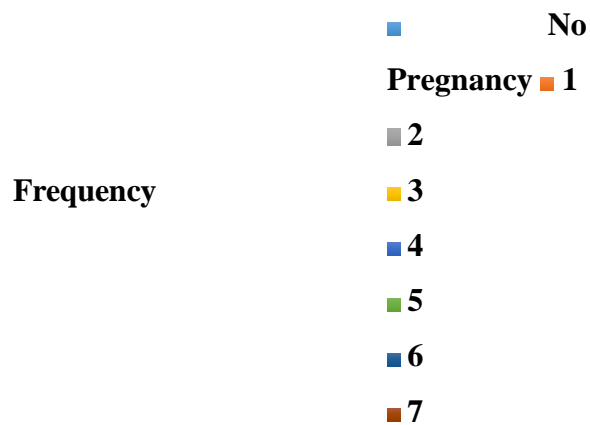


Figure 5: Bar Chart of Descriptive Statistics for Previous Pregnancies

Table 7

Descriptive Statistics for the Number of Children

Number of Children	Frequency	Percent
0	67	25.8
1	58	22.3
2	72	27.7
3	31	11.9
4	17	6.5
5	10	3.8
6	4	1.5
7	1	0.4

The data illustrates the distribution of individuals based on the number of children they have. The largest group consists of individuals with two children, making up 27.7% of the total. Those with no children and one child follow, accounting for 25.8% and 22.3%, respectively. Together, these three groups represent over 75% of the population. Individuals with three children constitute 11.9%, while smaller groups, such as those with four children (6.5%), five children (3.8%), six children (1.5%), and seven children (0.4%), show a gradual decrease in frequency. This distribution suggests that most individuals in this dataset have two or fewer children, with significantly fewer people having larger families. These trends may reflect social, economic, or cultural influences on family size.

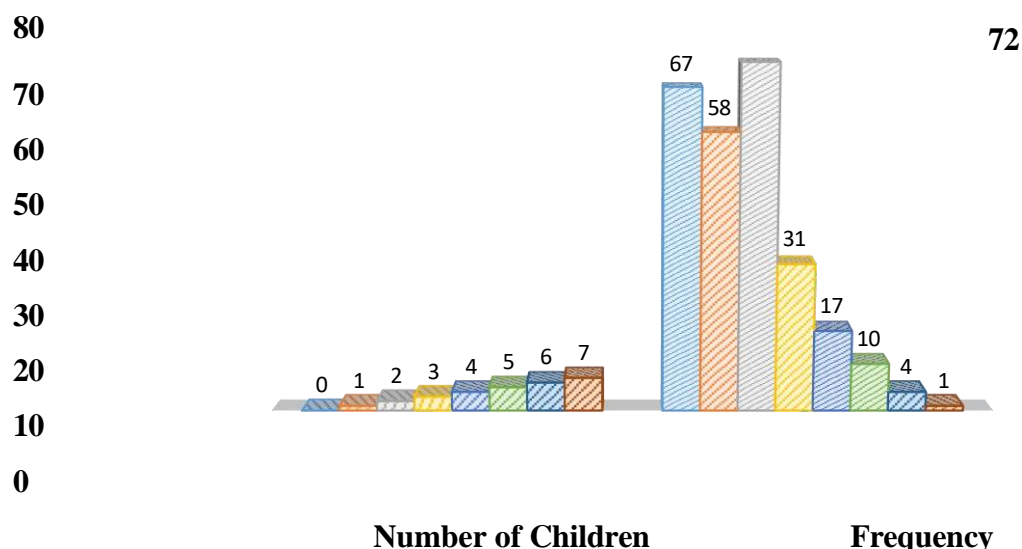


Figure 6: Bar Chart of Descriptive Statistics for Number of Children

Table 8

Descriptive Statistics for Model of Previous Delivery

Mode of Delivery	<i>Frequency</i>	<i>Percent</i>
C-Section	128	49.2
SVD	77	29.6

The data represents the distribution of delivery modes among individuals. The most common mode of delivery is a C-section, which accounts for 49.2% of the total. This is followed by SVD (Spontaneous Vaginal Delivery), representing 29.6% of the total. The data suggests that nearly half of the individuals in this group have had a C-section, while a smaller proportion have experienced a vaginal delivery without assistance. The relatively high percentage of C-sections may reflect various medical, social, or health-related factors influencing delivery choices or circumstances in this population.

■ C-Section ■ SVD

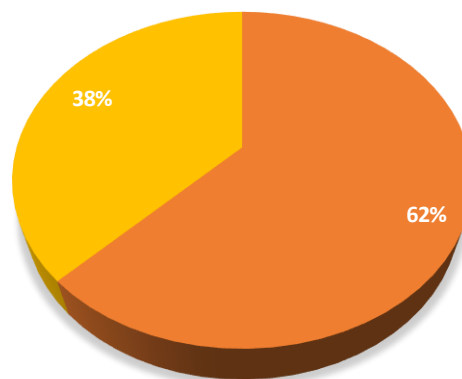


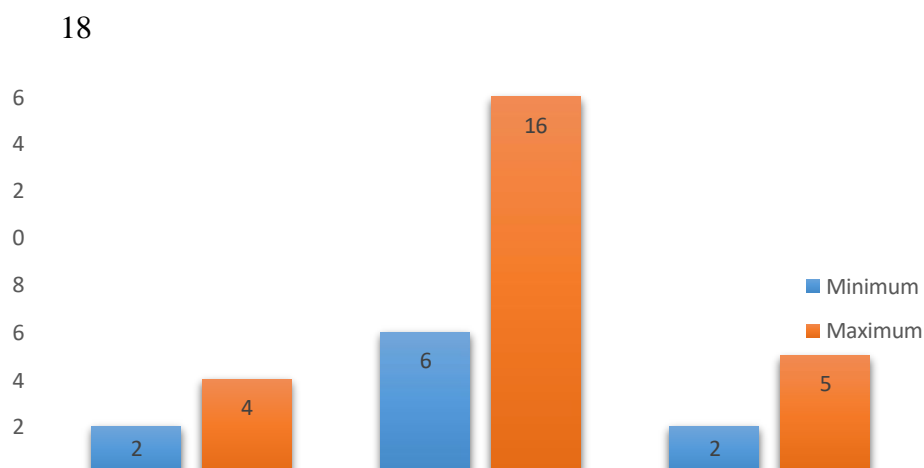
Figure 7: Pie Chart for Descriptive Statistics of Mode of Previous Delivery

Table 9

Descriptive Statistics for Composite Score of Knowledge, Attitude, Practice

Variables	Minimum	Maximum	Mean ± Standard Deviation
Knowledge Composite Score	2.00	4.00	2.4286 ± 0.56
Attitude Composite Score	6.00	16.00	8.3661 ± 2.34
Practice Composite Score	2.00	5.00	2.9767 ± 0.97

The descriptive statistics of the composite scores of Knowledge, Attitude, and Practice provide insights into the participants' responses. The Knowledge Composite Score was observed to be between 2.00 and 4.00 and had a mean of 2.43 ± 0.56 , depicting that the participants scored relatively closer to the lowest score with moderate variation. The score of participant's attitude varied between 6.00 and 16.00 with a mean (\pm SD) of 8.37 ± 2.34 , indicating a fairly good attitude of participants with moderate variations. The Practice Composite Score showed that participants were performing 29% of the recommended practices at $-0.9 \pm 0.95\sigma$, which suggests there is much room for improvement. In general, the knowledge and practice scores are clustered more towards the lower to middle range, whereas attitude scores are more diversely distributed.





0

Knowledge Composite Score

Attitude Composite Score

Practice Composite Score

Figure 8: Bar Chart of Descriptive Statistics for Composite Scores of Knowledge, Attitude, and Practice

Table 10

Effect of Education, Occupation, and Place of Residence on Knowledge, Attitude and Practice (MANOVA)

Source	Dependent Variable	Mean Square	P-value
Education	Knowledge Score	0.406	0.278
	Attitude Score	11.789	0.078
	Practice Score	1.026	0.347
Occupation	Knowledge Score	0.669	0.121
	Attitude Score	12.801	0.085
	Practice Score	0.736	0.453
Place of Residence	Knowledge Score	0.48	0.218
	Attitude Score	0.328	0.801
	Practice Score	1.03	0.293

As per the table, attitude scores are significantly affected by the level of education and the occupation status, implying that they determine the attitude of females towards cesarean delivery. The type of knowledge that the females possess regarding a cesarean section shows a significant effect on their occupation and place of residence, even though their practice about the C-section didn't affect them significantly.

Table 11

Inter-correlation among Demographic Variables and Key Study Variables (Knowledge, Attitude, Perception, and Practice)

Variables	1	2	3	4	5	6	7
1. Age	-						
2. Education	0.15	-					
3. Occupation	0.05	0.10	-				
4. Income	-0.12	0.05	0.10	-			
5. Family Background	0.20*	0.15	0.12	0.05	-		



6. Place of Residence	-0.05	0.08	0.06	-	0.06	-	
				0.03			
7. Marital Status	0.01	-0.05	0.05	0.01	0.02	0.03	-
8. Knowledge	0.15	0.30**	0.05	-	0.20*	-	0.01
				0.12		0.05	
9. Attitude	0.10	0.12	0.10	0.05	0.15	0.08	-
							0.05
10. Perception	0.17*	0.35**	0.12	-	0.18*	0.06	0.05
				0.09			
11. Practice	0.18*	0.24**	0.13	-	0.25**	-	0.01
				0.16		0.03	

Note: ($N=250$), $*p<0.05$, $**p<0.01$ (2-tailed); GL=Geographical Location, FB=Family Background, MS=Marital Status, KCS=Knowledge of C-sections Scale, ATCS=Attitudes Toward C-sections Scale, PCNS=Perception of C-section Necessity Scale, K6=Kessler Psychological Distress Scale

The correlation of the demographic variables and their effects on the knowledge, attitude, and perception of women towards C-section. The first one refers to a table entitled "Correlation of Women's Knowledge, Attitude, and Practice about C-Section by their Demographic Variables". The findings, which are mainly based on the statistical correlation of the variables have been discussed in this article. Studies suggest that education is important for health literacy, which empowers women to make correct decisions during delivery. Research in the habitat and family structure of the women also made a significant difference in this practice as well. This finding suggests that women from supportive family environments may have greater access to information and feel more confident in making health care decisions, as family members often influence delivery choices in many cultures, particularly in **Pakistan**. However, **place of residence** (urban vs. Rural) showed no significant correlations, which challenges the common assumption that urban women, with better access to healthcare facilities, would be more knowledgeable or have more positive views on medical interventions like C-sections. This indicates that **information access** and **cultural** may be more influential than geographic location in shaping perceptions about childbirth. Older women might have given birth before and thus might use their experience to make the right decision. However, age did not have any major effect on knowledge or attitudes



as per the survey results. Having c-section or vaginal deliveries in the past was moderately positively correlated with knowledge ($r=0.23$, $p<0.01$) and practice ($r=0.19$, $p<0.01$). This means these experienced women demonstrated greater knowledge and practice regarding delivery mode. The findings indicate that educational interventions should not be just for increasing knowledge. Rather, it should also include cultural and family factors. This will help all women, irrespective of their background, get the correct information on C-sections. With this, unnecessary C-sections may be reduced, and better maternal health outcomes may be achieved.

Discussion

The present study aimed to find how education, family background, age, and place influence knowledge, attitude, and perception about C-section among pregnant women. This study is of great value in Pakistan because cultural, social, and educational norms affect healthcare decisions. The results of this research help to understand the decision-making process of mothers about using health care, particularly about C-sections and indicate the major crucial interventions, particularly in antenatal care education.

The first key finding of this research is that education had a strong positive relationship with knowledge, attitudes, and perceptions regarding C-sections. Women who have an education have a better understanding of C-sections, a more favourable attitude towards C-sections, and a high probability of adopting recommended practices while choosing for childbirth. Corresponding to what has been stated before, health literacy is important for enhancing decision-making and empowering women to make informed choices [5]. Women who are educated are better capable of seeking and retaining healthcare information, which enables them to make informed decisions about their delivery. In Pakistan, there is a major difference between the literacy rate of the rural population and the urban one. That's why this finding of educated women might help in getting accurate information on c-sections and safety.

Age showed a weak correlation with knowledge, attitude, and perception, but showed a moderate positive correlation with practice, an important finding with significant implications. Older women tend to rely more on their experiences when opting for a C-section, especially those who have given birth before. This study's findings strengthen prior studies that find past delivery experience is a factor in decision-making by women [9].



But the women's age (i.e., Younger vs. Older) isn't responsible for their knowledge and attitudes regarding C-sections, so this indicates education and culture might be more important when it comes to this knowledge and attitudes. According to, education (rather than age) is more strongly related to the capacity to make health care decisions making [10]. The study also found that family background was quite important after education. Women residing in joint or extended families were more likely to be knowledgeable about C-sections and to display positive attitudes and positive practices regarding C-sections. Family support is crucial in influencing women's healthcare decisions, and this plays a huge role, particularly in cultures where the family is very much involved in decision-making. Having a big family can help, just like your husband can help with a tough decision. So this proves it can help improve health decisions. Cultural beliefs and family factors still shape healthcare practices, suggesting that family-centered interventions may be an effective strategy for improving maternal health outcomes.

Surprisingly, both location (urban, and rural) as well as knowledge, attitude, or practice did not correlate with C-section. I was surprised because people often assume the urban area has better access to care and education. However, the study shows that sociocultural factors (familial influence, cultural norms, health literacy, etc) seem to be more influential than geographical location (rural vs. Urban) in shaping women's perceptions of C-sections. As Felisian and Mushy suggest, even urban women in Pakistan face similar cultural barriers to C-sections as rural women, largely due to deep-rooted societal pressures surrounding vaginal birth. It calls for a more comprehensive approach to maternal education that is not only applicable to all geographic locations but also suits local contexts.

One of the most significant findings was that women's prior delivery experiences shaped their knowledge of and practice concerning C-sections. Women with earlier encounters with C-sections had more knowledge about it and felt more empowered to choose it again if medically required. Women who had experienced C/S were likely to choose it as their delivery option again for their next pregnancies [11]. Women must get accurate information about C-sections. This is even more essential for first-time mothers who may not know the procedure and its benefits.

Women's views about C-sections largely depend on the culture they belong to. In Pakistan, choosing a C-section may be seen as a sign of weakness because traditional



medicine views normal delivery as being more powerful and womanly, whereas a C-section is seen as an evasive choice. Many rural women who give birth by C-section often suffer from low self-esteem. They view vaginal birth as the ideal birthing method. The results suggest a need for culturally appropriate educational interventions addressing the biases against C-sections, as well as information on the safety, need, and benefits of C-sections. The cultural sensitivity of education could help in overcoming resistance and empowering women to make an informed choice free of pressure.

Conclusion

In short, the education of women plays a significant role in their decision-making regarding C-sections. Women with education had better knowledge and high confidence concerning their delivery decision-making. Support from family and past experience of delivery were also major influences on C-section knowledge and attitude. The geographical location of the families did not significantly affect the decision. Thus, it means that cultural and educational factors of the location are more important than the geographic location. The results point out that women should be provided with antenatal education programs that provide complete information about C-sections, irrespective of their location.

Limitations

Even though this study is useful, it has limitations. The sample may not be representative of the entire population because purposive sampling was used. This is especially true in rural areas. The results may not apply to all demographic sectors, especially those beyond the study's intended scope. Upcoming studies could use random sampling, which would help involve a diverse sample which will involve women from different SES and geographical areas. Also, being a cross-sectional study, it could not assess the dynamism of the knowledge and attitude. Studies over a longer period could help put a finer point on maternal knowledge and attitudes during pregnancy and after delivery.

Policy Implications

The findings of this study will help in future policies. First of all, a need to have educational material targeting women across various educational qualifications, especially in rural areas. These programs should give correct information on C-sections that follow the culture and other important factors, including their benefits. Policies for health must also help the family plays in maternal health decisions, and family-oriented



views should be promoted to help antenatal decision-making.

In addition, training healthcare providers to effectively communicate with women and their families can facilitate shared decision-making in the choice of delivery methods. Lastly, policymakers must try to change the culturally bad image of C-sections, mainly in rural areas, by moving the public health campaign, which could help women take it up for their safety.

Future Research Directions

Future research should examine how the media influences C-section decisions since the media shapes women's beliefs about childbirth. To further enhance our understanding of these perspectives, it would be valuable to conduct some qualitative research among women opting for a C-section in the rural versus urban context. Future research will help to improve health interventions and policies that promote informed and empowered decision-making among expectant mothers if these gaps are filled.

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